

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:

Medically Fragile, Technology Dependent

C. Waiver Number: IL.0278

Original Base Waiver Number: IL.0278.90.R1.01

D. Amendment Number:

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

07/01/26

Approved Effective Date of Waiver being Amended: 09/01/22

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) Add Assessment by Occupational or Physical Therapist as a new waiver service in Appendix C-1/C-3. The service allows occupational and physical therapists to assess the customer's home environment to determine the need for adaptive equipment, assistive technology, and home accessibility modifications.

2) Modify the Adaptative Equipment service definition in Appendix C-1/C-3 in the following manner:

- Remove the word "evaluation" from the 5th bullet as the cost for evaluations will now be a separate new service called Assessment by Occupational or Physical Therapist.
- Add additional items available under this service:
 - Standers, adaptive car seats, adaptive swings, adaptive bicycles, adaptive stroller, bath/shower chair
 - Electric Hoyer Lift, fall recovery, and mobility aids
 - Adaptive utensils, cookware, and dishes
 - Trampoline, sensory floor mats

3) Modify the Assistive Technology service definition in Appendix C-1/C-3 in the following manner:

- Delete the first bullet point stating, "the evaluation of the assistive technology needs of a customer...", as the cost for evaluations will now be a separate new service called Assessment by Occupational or Physical Therapist.

4) Modify Environmental Accessibility Adaptation service definition in Appendix C-1/C-3 to move the following language from the bottom of the definition to the beginning, in order to reduce stakeholder misunderstanding that this service still exists:

EFFECTIVE 1/1/2025 per IL.0278.R06.02, Environmental Accessibility Adaptations is no longer a waiver service. The services previously grouped under the Environmental Accessibility Adaptations service umbrella are now separate services.

The new separate services include:

- Pest Control
- Home Accessibility Modifications
- Vehicle Modifications

5) Modify the Home Accessibility Modification service definition in Appendix C-1/C-3 in the following manner:

- Added HCBS Taxonomy codes that had previously been omitted.
- Adding the following sentence to the first paragraph, "A private residence may encompass more than one residence when there is a shared custody arrangement involving joint legal and physical custody". This is being added to clarify that "private residence" considers shared custody arrangements and home accessibility modifications can be approved for more than one residence.
- Add the following language to the 2nd paragraph, regarding the administrative claiming for Home Accessibility Modifications in case of death or failure to transition to community per State Medicaid Director letter Olmstead Update #3 dated July 25, 2000, and for consistency with the approved service definition for Vehicle Modifications: "In the event the customer dies before going home (or is determined to be unable to go home) after the expenses have been incurred, the State will claim these expenses as administrative costs at the administrative FFP rate for services which would have been necessary for relocation to have taken place when the customer has applied for waiver service; and has been found eligible for the waiver by the State but died or was determined unable to go home, before the actual delivery of the waiver service".
- Generators: Change from "purchase or repair" to "purchase, install, or repair."
- Add orbit lift and stair lift to the list of examples of home accessibility modifications.
- Revise the 1st dot point of the 3rd paragraph (Ramps, house lifts...) to delete the verbiage "or leave home to access a bedroom or bathroom..." and change to "access areas within the home". The revised example is as follows: Ramps, house lifts, overhead lifts, or elevators necessary to enter or leave the home or to access any area within the home, including porch or stair lifts and hydraulic, manual, or electric lifts.
- Delete the dot point "Replacement of floor covering; replacement or repair of stairs, windows, driveways, or sidewalk", under the excluded adaptations or improvements in the 4th paragraph of the service definition.

6) Modify the Pest Control service definition in Appendix C-1/C-3 in the following manner:

- Add "setting of traps" to the 2nd paragraph which details the allowable Pest Control activities.
- Add the following language to the 4th paragraph, allowing the State administrative claiming for Pest Control services in case of death or failure to transition to community per State Medicaid Director letter Olmstead Update #3 dated July 25, 2000: "In the event the customer dies before going home (or is determined to be unable to go home) after the expenses have been incurred, the State will claim these expenses as administrative costs at the administrative FFP rate for services which would have been necessary for relocation to have taken place when the customer has applied for waiver service; and has been found eligible for the waiver by the State but died or was determined unable to go home, before the actual delivery of the waiver service".

- 7) Add the following verbiage to the service definition for Placement Maintenance Counseling Services in Appendix C-1/C-3: Placement Maintenance Counseling is being removed as a waiver service as it is not necessary. Placement Maintenance Counseling is covered under EPSDT and/or the Medicaid State Plan.
- 8) Add the following verbiage to the service definition for Specialized Medical Equipment in Appendix C-1/C-3: Specialized Medical Equipment is being removed as a waiver service as it is not necessary. All equipment or supplies needed to maintain a customer in the home and the coverage of operational and maintenance costs of equipment are available through EPSDT and/or the Medicaid State Plan or under Adaptive Equipment and Assistive Technology.
- 9) Revise the first sentence in the Limits section for Nurse Training in Appendix C-1/C-3 to add “per child”.
- 10) Update the Provider Qualifications – Other Standard section in Appendix C-1/C-3 to add the following language (that providers must) “Be in good standing in accordance with OA policy” for the following Provider Types: Respite - Children's Community-Based Health Care Center and Approved Nursing Agency; Adaptive Equipment - Equipment Vendors; Assistive Technology - Equipment Vendors; Certified Nursing Assistant (CNA) - DSCC Approved Nursing Agency; Environmental Accessibility Adaptations – Contractor; Family Training – Approved Service Agency and OA Approved Nursing Agency; Home Accessibility Modifications – Contractor; In-Home Shift Nursing - DSCC Approved Nursing Agency; Nurse Training - OA Approved Nursing Agency; Pest Control; Vehicle Modifications - Equipment Vendor and Installer.
- 11) Add clarifying language to the 1st paragraph in Appendix C-2-e, to state: "Relatives/legal guardians employed by a Home Nursing Agency approved by the MA and OA, may be paid for providing respite services if they do not live/reside in the same home as the customer lives.”
- 12) Update Appendices C-5, D-1-d, D-1-d-ii, and D-2-a to reflect changes resulting from the 3.7 software change.
- 13) Updated Appendix C Quality Improvement - Performance Measures C1, C2, C3, and C4 to change the Responsible Party for data collection/generation to the OA and change the Data Source to OA reports.
- 14) Revise Performance Measure D7 to change the sampling approach to 100%.
- 15) Revise Appendices A-2-b, D-1-g, and D-2-a remove references to the MA doing desk audits of customer records and replace with the following language: The MA will conduct validation reviews of the OA's quality assurance reviews by pulling a sample of records reviewed by the OA. The MA will review in order to ensure comparable findings between MA and OA reviewers.
- 16) Update Appendices F-3-a, F-3-b, and F-3-c to include Operating Agency's grievance procedures required by the federal Access Rule implementation deadline of 7/1/2026.
- 17) Delete Performance Measure G7, as it was a duplicate of Performance Measure G6.
- 18) Add the required remediation action for Performance Measure G9, which was inadvertently missing from the previous waiver version.
- 19) Add the following language to Appendix H-1-a: The MA will conduct validation reviews of the OA's quality assurance reviews by pulling a sample of records reviewed by the OA. The MA will review in order to ensure comparable findings between MA and OA reviewers.
- 20) Add language in Appendix I-2-a for the new service Assessment by an Occupational or Physical Therapist. The rate of \$111 per visit (up to 2 hours). This rate is the same as the State Plan rate.
- 21) Change the sampling approach for Performance Measures I1 and I3 from 100% to representative sampling with a 95% confidence level with a +/- 5% margin of error.
- 22) Edit I-2-a (in Main B Optional) to add the new service Assessment by an Occupational or Physical Therapist.
- 23) Update Appendix J-2-d for cost estimates for the new waiver service Assessment by an Occupational or Physical Therapist.

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	
Appendix A - Waiver Administration and Operation	A-2-b
Appendix B - Participant Access and Eligibility	
Appendix C - Participant Services	C-1/C-3, C-2-e, C-5, Quality Improvement
Appendix D - Participant Centered Service Planning and Delivery	D-1-g, D-2-a
Appendix E - Participant Direction of Services	
Appendix F - Participant Rights	F-3-a, b, c
Appendix G - Participant Safeguards	Quality Improvement
Appendix H	H-1-a
Appendix I - Financial Accountability	I-2-a, Quality Improvement
Appendix J - Cost-Neutrality Demonstration	J-2-d-1

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

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

Revise Appendix F to comply with federal HCBS Access Rule requirements effective 7/1/2026.

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):

Medically Fragile, Technology Dependent

C. Type of Request: amendment

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

3 years 5 years

Original Base Waiver Number: IL.0278

Draft ID: IL.002.06.03

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 09/01/22

Approved Effective Date of Waiver being Amended: 09/01/22

PRA Disclosure Statement

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:

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:

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:

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 Illinois home and community-based services waiver for Persons who are Medically Fragile, Technology Dependent (MFTD) was created to allow eligible customers to receive medically necessary supports in their own homes. The goal is to provide those needed supports in a way that maximizes independence and community integration. The waiver is intended to supplement supports for eligible customers who are medically fragile, technology dependent, by providing waiver specific services and other medically necessary services for those whose medical needs meet the institutional level of care. The waiver includes the following services: respite, specialized medical equipment and supplies, adaptive equipment, assistive technology, home accessibility modifications, vehicle modifications, pest control, family training, in-home shift nursing for customers over 21 years of age, nurse training, and placement maintenance counseling services for all customers. For those under 21 years, in-home shift nursing is covered through the EPSDT.

The Department of Healthcare and Family Services (HFS), the Medicaid Agency (MA) has delegated the day-to-day operations for the waiver to the University of Illinois at Chicago, Division of Specialized Care for Children (DSCC), as the operating agency (OA). The OA provides care coordination, quality assurance and bill processing and prior approval for the waiver. The MA and OA have entered into an interagency agreement that outlines the respective roles and responsibilities for each agency. The interagency agreement is reviewed annually and updated as needed. The OA is the lead agency for community-based services and supports to children who are medically fragile, technology dependent. The OA is responsible for initial screening of applicants, Person Centered Plan (PCP) development and implementation, enrolling waiver providers, reporting to the MA, and assuring services and providers meet established standards. The MA determines eligibility, enrolls providers in Medicaid, provides oversight, consultation and monitoring, processes federal claims and maintains an appeal process.

The waiver is part of DSCC's Home Care Program, that serves as the single point of entry for in-home shift nursing services in Illinois. The Home Care Program provides care coordination services to all persons in Illinois that meet the criteria for in-home nursing care. The customers served in the waiver are at risk for institutional level of care, while the non-waiver customers do not meet the LOC eligibility requirements; but do need shift nursing in the home. The non-waiver customers are under 21 years and are served through the EPSDT Program under Medicaid. There are six regional offices within Illinois that provide care coordination and a central office that provides direction to the regional offices as well as monitoring and oversight.

Eligibility:

Under the interagency agreement, the Operating Agency (OA) serves as single point of entry for in-home shift nursing services and is the designated care coordination entity for those receiving in-home shift nursing. The OA also refers applicants to the Medicaid Agency (MA) for eligibility determinations.

Waiver eligibility determinations (initial and annual) are conducted by a team of nurse consultants at the MA. The OA performs a comprehensive assessment that is shared with the MA, along with medical reports. Through this comprehensive assessment the OA Care Coordinator builds a relationship with the family by gaining an understanding of their perspective, gathering information, identifying their strengths and understanding the family's needs and goals. The assessment gathers data in the following areas: health, social/emotional, educational, financial, and transition. In order to be eligible for the waiver, applicants and enrollees must meet a minimum score on the MA approved level of care (LOC) tool to be eligible for the waiver. The MA has final approval of all eligibility determinations.

Continued in Main 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. Statewide. Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):

No

Yes

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

Geographic Limitation. A waiver of statewide requirements 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 statewide requirements 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 3/23/2026, this proposed waiver amendment was sent to the tribal government and posted for public notice to the website of the Illinois Department of Healthcare and Family Services, <http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx>; providing for a 30-day comment period ending 4/22/2026.

This proposed waiver amendment is also provided via a non-electronic method of public distribution. A copy of the proposed amendment was posted at Illinois Department of Human Services (IDHS) local offices throughout the state, except in Cook County. In Cook County, the notice is available at 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 University of Illinois at Chicago, Division of Specialized Care for Children, the Operating Agency for the waiver, emailed notification of opportunity for comment on this proposed waiver amendment to its stakeholders and other interested parties.

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.

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:

Pamela

Title:

Bureau Chief, HCBS Waiver Operations Management

Agency:

Department of Healthcare and Family Services

Address:

201 South Grand Avenue East - 2nd Floor

Address 2:

City:

Springfield

State: Illinois

Zip:

62763

Phone:

(217) 782-6359

Ext:

TTY

Fax:

(217) 557-8604

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:

Leach

First Name:

Stephanie

Title:

Associate Director of Systems of Care

Agency:

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

Address:

3135 Old Jacksonville Road

Address 2:

City:

Springfield

State:

Illinois

Zip:

62707-6488

Phone:

(217) 558-2350

Ext:

TTY

Fax:

(217) 558-0773

E-mail:

sleach1@uic.edu

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under 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:

E-mail:

Attachments**Attachment #1: Transition Plan**

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

None of the proposed changes will have a negative impact on customers.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

MAIN B OPTIONAL

Continued from Main 2) Program Description:

Care Coordination and Support Planning:

Once eligibility is established, the OA's team of licensed professionals (registered nurses, social workers, and bachelor-prepared persons with degrees in social science, social work or in a related field, and two years of experience) will provide ongoing care coordination. The Person-Centered Plan (PCP) is developed jointly with that family, customer, the OA's care coordination team, and others as designated by the family.

The PCP is customer centered and is developed following the comprehensive assessment, which serves as the discovery portion of the PCP. Care coordination begins with an initial comprehensive assessment of the customer and family's strengths and needs. Through this initial assessment (and then ongoing assessments), the Care Coordinator builds a relationship with the customer and family by gaining an understanding of their perspective, gathering information, identifying their strengths and understanding the customer and family's needs and goals. The assessment process is designed so that it ultimately allows the customer and the family to lead the in the development of a PCP. The care coordination team assists the family with accessing needed waiver and State plan services, as well as medical, social, educational and other services, regardless of the funding source. The family and customer guide the PCP and use of services based on their preferences and goals.

Customers in the MFTD waiver are informed of their rights and responsibilities and their role in the PCP process. Rights and responsibilities are defined in brochures and validated at various points of the assessment and planning processes with signatures and other affirmations documenting participation and acknowledgement. The customer and provider(s) responsible for the implementation of the PCP receive a copy of the PCP.

Care Coordinators are trained to educate customers on available providers and assist in making informed choices. Customers are given choices and may receive one or more waiver services. Other services are available through other local and state funding sources and may be included in the PCP in addition to waiver services.

The OA uses all willing and qualified providers for providers seeking enrollment in the Medicaid program. OA staff ensure that providers meet OA standards prior to providing services.

Health and Safety:

The OA recognizes the importance of communication, and encourages personal interactions with customers, families and community partners including home visits, site visits, interdisciplinary meetings, attending medical appointments and educational meetings with customers, families, etc. In between face-to-face contacts, staff will use phone, email, video conferencing, and mail correspondence to develop and maintain trusting relationships, facilitate communication, update assessments, and collaborate on projects with customers, families and other organizations.

Required Contacts: The OA Care Coordinators attempt to contact customers/families, at least every 30 days. Although contacts are attempted every 30 days, a successful contact is required every 90 days. These routine contacts are referred to as focused assessments. The Care Coordinator focuses on topics that are important to and important for the customer and family such as: updates related to health (including medications, appointments, insurance coverage); social/emotional well-being; education; finances; transition issues; and PCP goals. This provides an opportunity for the care coordination team and customer/family to discuss current status, concerns and resolutions. The customer/family is also contacted within the first week of implementation of home care services and/or discharge to home from the hospital. Annual home visits are also a requirement of the OA, as well as an additional face-to-face visit within the year. Care Coordinators notify the MA of significant changes in a customer's medical condition or home environment that may impact the customer's health and safety, so that additional supports may be considered.

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

Quality Improvement:

An entity called the Family Advisory Council advises the OA on an ongoing basis on recommendations regarding issues affecting service delivery. The Family Advisory Council helps guide the program and adds to the quality of life of the

customers. The MA attends all MFTD stakeholder meetings and actively participates to clarify Medicaid or waiver policy.

The MA and the OA maintain separate but complementary processes to monitor customer welfare, service access, and quality. The OA conducts ongoing quality assurance of care coordination activities, and the nursing agency and home medical equipment providers, including verification of provider qualifications and provider training. The OA provides the MA with reports of their monitoring activities, including sanctions. The MA conducts separate quality assurance reviews of the OA to ensure compliance with delegated activities in the approved waiver.

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

CONTINUED FROM G-2-a-i: The use of restraints is permitted during the course of the delivery of waiver services. The waiver provides in-home shift nursing to adults (age 21 and over) as this service is not covered in the Illinois State Plan. In-home shift nursing is different than intermittent nursing because customers require hourly shift nursing rather than an intermittent visit, to perform a specific task. These services are provided by RNs and LPNs that meet Illinois licensure standards for nursing services. RNs and LPNs may only provide services authorized through their licensure type. Services may include the following. Registered Nurses may provide and coordinate care, educate the customer and the public about various health conditions, and provide advice and emotional support. Registered Nurses duties may also include recording medical histories and symptoms, administering medications and treatments, developing the nursing plan of care or contributing to existing plans, observing and recording findings, consulting with doctors and other healthcare professionals, operating and monitoring medical equipment, assisting in the performance of diagnostic tests, analyzing the results, teaching how to manage illnesses or injuries, as well as explaining at home treatment options. Licensed Practical Nurses provide basic medical care, under the direction of registered nurses and doctors. LPN's duties may include but are not limited to administering basic nursing care, monitoring health by checking blood pressure, changing bandages, inserting catheters, providing basic comfort, including bathing and dressing, as well as discussing health care with the customers and families, addressing concerns, while keeping adequate records regarding health, and reporting pertinent information to registered nurses and physicians.

Provider agency employees consisting of Nursing are required to receive customer specific training prior to the initiation of rendering service, shall include:

1. the use of less restrictive alternatives,
2. safe application of restraints,
3. required monitoring,
4. documentation requirements.

CONTINUED FROM I-2-B:

Amendment IL.0278.R06.03, effective 07/01/2026 or upon CMS approval:

Assessment by Occupational or Physical Therapist:

The OA Care Coordinator obtains the prior approval request from the potential vendor and submits it to the OA Prior Approval Unit. The OA Prior Approval Unit reviews the request including the scope of work to be provided and verifies that the need for the assessment is supported in the Person-Centered Plan. The OA Prior Approval Unit also reviews to verify that the assessment relates to one or more of the following services: home accessibility modifications, assistive technology, or adaptive equipment. If approved, the OA prior approval unit sends written notification to the OA Care Coordinator that the service has been authorized. The OA Care Coordinator contacts the family and/or vendor. The claim is received by the OA Care Coordinator who verifies the assessment was provided. If approved, the request is forwarded to the MA for payment using a manual (C-13) voucher 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:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

University of Illinois at Chicago, Division of Specialized Care for Children (UIC-DSCC)

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Medicaid Agency (MA) maintains an interagency agreement with the Operating Agency (OA) that outlines the roles and responsibilities for both agencies, and outlines delegation of functions. The interagency agreement is reviewed at least annually and amended if necessary.

The MA delegates the care coordination, quality assurance oversight, some claims processing activities, and some prior approval functions to the University of Illinois at Chicago (UIC), Division of Specialized Care for Children (DSCC) as the Operating Agency (OA). The OA consults the MA about all waiver rule and policy changes before submission to the MA Medical Policy Review Committee.

The MA's Medical Policy Review Committee reviews all waiver rule and policy changes. All waiver policy and rule changes must be approved by the MA prior to implementation.

The specific OA delegated responsibilities include: serving as single point of entry in-home shift nursing; conducting comprehensive assessments and ongoing focused assessments of waiver customers; gathering medical documentation and conducting a pre-Level of Care assessments prior to forwarding to the MA for final decisions, gathering financial information for Medicaid eligibility determinations; developing the PCP with the customer and their family; overseeing the health and safety of waiver customers; quality assurance monitoring of Care Coordinators, nursing agencies and home medical providers; serving as the claims processing entity for respite, in-home nursing and nurse training services and prior approval for the following services: home accessibility modifications, vehicle modifications, generators, pest control, adaptive equipment and assistive technology.

The MA enrolls providers in Medicaid, processes federal claims, maintains an appeal process, determines waiver eligibility, approves certain waiver services and State plan services, and approves all policy changes and rate changes.

The MA conducts all waiver appeal hearings and issues final determination decisions. The MA does not delegate this function to the OA. The MA provides independent, trained hearing officers for all appeal hearings. The MA provides the OA data, reports, or information as may be required to ensure compliance with State and Federal licensure and certification requirements and quality monitoring responsibilities.

The MA oversight of PCPs includes the following:

- 1) The MA randomly selects a statistically valid sample from customers enrolled in the waiver using a 95% confidence level and a +/-5% margin of error and reviews the PCPs as well as other waiver specific requirements such as required contacts and timely and accurate completion of assessments. The OA then submits findings and remediation to the MA. The MA assures compliance with federal and state regulations.
- 2) The MA will conduct validation reviews of the OA's quality assurance reviews by pulling a sample of records reviewed by the OA. The MA will review in order to ensure comparable findings between MA and OA reviewers.

Level of Care—The MA conducts the LOC and makes all eligibility decisions based on a preliminary LOC completed by the OA and medical reports.

Qualified Providers—Responsibility for provider enrollment is a joint MA and OA activity. The OA does preliminary screening for qualified providers who are then approved by the MA and enrolled in the IMPACT system. The OA Quality Improvement unit is responsible for assuring that nursing agencies meet waiver requirements.

PCP—Customer records are examined to determine that all assessed customer needs, goals, and risks are addressed in the PCP; services are provided according to the PCP; PCPs are signed and dated by the customer and Care Coordinator; customers are contacted by the Care Coordinator per applicable waiver requirements; PCPs are updated when the customer's needs change; and that choice of services and providers was offered to the customer. PCPs are also reviewed for completeness, accuracy, and timeliness.

Health, Safety, and Welfare—Customer records are reviewed to determine that customers are aware of how and to whom to report abuse, neglect, and exploitation; and each customer has a backup plan.

Remediation—The OA submits a report of findings to the MA at the conclusion of each onsite review. The report

consists of a summary of findings for each customer record reviewed, as well as a summary of overall findings detailed by Performance Measure and contractual requirements reviewed.

Remediation activities are tracked by the OA to ensure 100% remediation of findings. Timeframes for completion of remediation will be reported in 30, 60, 90, or greater than 90 days. Remediation activities will be consistent with the approved activities detailed within each Performance Measure.

Sampling—the OA’s sampling methodology is based on a statistically valid sampling approach that uses a 95% confidence level and a +/-5% margin of error.

The MA provides the OA data, reports, or information as may be required to ensure compliance with State and Federal licensure and certification requirements and quality monitoring responsibilities.

The MA and OA both conduct routine oversight and monitoring activities of the fiscal and program activities to ensure that the State meets federal assurances and accountability identified in the waiver.

The MA maintains the appropriation and establishes the statewide rate methodologies with respect to the waiver. The MA approves all level of care determinations and establishes prior authorization of certain waiver services and all State Plan services.

The OA consults with the MA in the development of monitoring protocols with respect to the waiver. All monitoring protocols and tools must be introduced at quarterly meetings and approved by the MA.

The OA and MA provide Performance Measure (PM) reports quarterly and annually. The OA and MA work jointly on aggregation and analysis of these reports.

The OA provides reports on remediation of identified issues quarterly and annually. The OA and MA jointly review and analyze these reports.

The OA receives all death reports for waiver customers and is then responsible for reporting death reports to the MA.

The MA participates with the OA, or makes reasonable effort to attend, in training and informational sessions as necessary.

The MA attends, or makes reasonable effort to attend, the OA’s salient internal meetings with agency stakeholders and other pertinent parties. MA waiver management staff are invited to all agency stakeholder meetings.

MA and OA staff communicate regularly regarding any issues that arise relating to administration of the waiver. These topics include general waiver administration, quality improvement strategies, HCBS Rule transition, etc. with respect to the waiver.

MA holds quarterly meetings with the OA to review program administration and evaluate system performance. Quarterly meetings also discuss broad topics, site reviews and remediation activities unless circumstances warrant communication prior to these meetings. The agencies also communicate regularly to follow up on issues raised during quarterly meetings.

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

Appendix A: Waiver Administration and Operation

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

Not applicable

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver administration. Thus this section does not need to be completed.

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:

As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver

administration. Thus this section does not need to be completed.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state

agencies (if appropriate) and contracted entities.

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

A1: Number and percent of substantive waiver changes where Public Notice and Tribal notifications were completed in accordance with CMS regulations. N: Number of substantive waiver changes where Public Notice and Tribal notifications were completed in accordance with CMS regulations. D: 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(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:

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

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

If 'Other' is selected, specify:

MA Meeting Log

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 (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 active waiver customers compared to the approved waiver capacity. **N:** Number of active waiver customers compared to the approved waiver capacity.

D: Total number of CMS approved waiver slots by waiver year.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS Data Warehouse

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

Data Aggregation and Analysis:

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

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:

A4: # and % of survey respondents who receive services in their home or community that report they are able to participate in meaningful activities that help meet their goals/needs.

N: # of survey respondents who receive services in their home or community that report they are able to participate in meaningful activities that help meet their goals/needs. **D:**

Total # of survey respondents.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA Survey

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

	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:

A5: Number and percent of survey respondents who report feeling supported in making decisions to remain independent to the greatest extent possible. **N:** Number of survey respondents who report feeling supported in making decisions to remain independent to the greatest extent possible. **D:** Total number of survey respondents.

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

If 'Other' is selected, specify:

OA Survey

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

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 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 <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:

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

- 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 OA reviews and reports data on a quarterly basis. This performance data is then presented by OA Quality staff to the Regional Care Coordination Teams through a post-review discussion which focuses on strengths, root cause, patterns and trends, and compliance. At the time of the post review discussion all findings are shared and timelines for remediation are initiated. Systemic issues are discussed with input from regional teams on causes and resolutions.

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 Operating Agency (OA) submits outstanding substantive changes to the Medicaid Agency (MA) for approval. If remediation is not within 30 days, the OA reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

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

A3: The OA 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.

A4: The OA Quality Improvement Team will survey the customer and review responses. The OA will continue to follow-up with customer to determine satisfaction. If no change, the OA Quality Improvement Team will follow-up until resolution. Initial follow-up will occur within 30 days of the finding.

A5: The OA Quality Improvement Team will review interview responses and will follow up with the customer to address their satisfaction. The OA will continue to follow-up with customer to determine satisfaction. If no change, the OA Quality Improvement Team will follow-up 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:

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

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			
		Disabled (Physical)			
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile	0		
		Technology Dependent	0		
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:

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

The waiver also includes customers who were enrolled in the waiver up to the day before turning 21 years of age and are now over 21 years of age.

Other criteria:

- 1) Meet the minimum score on the Illinois approved level of care (LOC) tool.
- 2) Be a U.S. citizen or legal alien
- 3) Be a resident of the State of Illinois
- 4) Be Medicaid eligible (with waiver of parental income)
- 5) Qualify as a person with a disability, as defined under the federal Supplemental Security Income program
- 6) Be at risk of hospital or nursing facility placement as measured by the minimum score on the Illinois approved level of care (LOC) tool.
- 7) Be safely maintained in the home or community-based setting.

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

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

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

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

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

The waiver program is designed to support families in providing in home supports to technology dependent customers with complex medical needs and to offer ongoing care coordination. Parents or caregivers are required to demonstrate the skills needed to provide all of the customer's care needs prior to beginning home care. The State Plan also provides Transitional Care Services to customers that are discharged from a hospital setting, but not ready to go home. The Transitional Care provider works with the family and primary care physician to prepare for permanent discharge to home.

The Level of Care (LOC) assessment and the comprehensive assessment will be completed to identify medical fragility and technology needs; risks and strengths, as well as caregiver, educational and social supports in place. These assessments will be used to develop a customer and family centered PCP. The care coordination support is individualized based on the customer's assessed medical needs and other risks. The PCP identifies all services and supports - both formal and informal, the need for additional evaluation(s), customer and family expressed goals, needs and wants, and service arrangements. It also includes identification of service needs being met by existing support systems including public, private, family and community and those funded by programs other than the Illinois HCBS services provided through the MFTD waiver. Care Coordinators are trained to utilize other local, state, and federal funded services when available to assist in meeting customers' needs and fill-in gaps where traditional waiver services are not available or adequate.

Families are notified of decisions for approval or denial of services via the HFS 2352 Notice of Decision on Request for Medical Services/Item, to initiate, change or terminate services. The HFS 2352 contains information about the right to appeal and the process to be used. If an appeal is initiated by the date a reduction or discontinuance is scheduled to occur or within ten (10) calendar days of the date of the adequate notice, services will be continued at the level in effect prior to the proposed action, pending the results of the fair hearing process, unless the individual specifically requests that his or her services not be continued. The Fair Hearing process is further defined in Appendix F.

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

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

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

Each customer is assessed on an individual basis to determine whether additional services are needed to serve the customer safely in the home. The need and approval of additional services will be determined by the MA.

As part of the focused assessment, families are informed to notify the Care Coordinator if needs change that may require additional services, including hospitalizations.

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

The OA Care Coordinators monitor the implementation of the PCP and report problems to the MA as indicated.

Other safeguard(s)

Specify:

- 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	1588
Year 2	1696
Year 3	1804
Year 4	1912
Year 5	2020

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

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

The state limits the number of participants that it serves at any point in time during a waiver year.

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

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

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

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

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

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

The waiver provides for the entrance of all eligible persons.

Appendix B: Participant Access and Eligibility

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

Waiver Phase-In/Phase-Out Schedule

Based on Waiver Proposed Effective Date: 09/01/22

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: 1336

Phase-In/Phase-Out Schedule

Waiver Year 1			
Unduplicated Number of Participants: 1588			
Month	Base Number of Participants	Change	Participant Limit
Sep	1336	9	1345
Oct	1345	9	1354
Nov	1354	9	1363

Waiver Year 2			
Unduplicated Number of Participants: 1696			
Month	Base Number of Participants	Change	Participant Limit
Sep	1444	9	1453
Oct	1453	9	1462
Nov	1462	9	1471

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
Dec	1363	9	1372
Jan	1372	9	1381
Feb	1381	9	1390
Mar	1390	9	1399
Apr	1399	9	1408
May	1408	9	1417
Jun	1417	9	1426
Jul	1426	9	1435
Aug	1435	9	1444

Month	Base Number of Participants	Change	Participant Limit
Dec	1471	9	1480
Jan	1480	9	1489
Feb	1489	9	1498
Mar	1498	9	1507
Apr	1507	9	1516
May	1516	9	1525
Jun	1525	9	1534
Jul	1534	9	1543
Aug	1543	9	1552

Waiver Year 3

Month	Base Number of Participants	Change	Participant Limit
Sep	1552	9	1561
Oct	1561	9	1570
Nov	1570	9	1579
Dec	1579	9	1588
Jan	1588	9	1597
Feb	1597	9	1606
Mar	1606	9	1615
Apr	1615	9	1624
May	1624	9	1633
Jun	1633	9	1642
Jul	1642	9	1651
Aug	1651	9	1660

Waiver Year 4

Unduplicated Number of Participants: 1912

Month	Base Number of Participants	Change	Participant Limit
Sep	1660	9	1669
Oct	1669	9	1678
Nov	1678	9	1687
Dec	1687	9	1696
Jan	1696	9	1705
Feb	1705	9	1714
Mar	1714	9	1723
Apr	1723	9	1732
May	1732	9	1741
Jun	1741	9	1750
Jul	1750	9	1759
Aug	1759	9	1768

Waiver Year 5

Unduplicated Number of Participants: 2020

Month	Base Number of Participants	Change	Participant Limit
Sep	1768	9	1777
Oct	1777	9	1786
Nov	1786	9	1795
Dec	1795	9	1804
Jan	1804	9	1813
Feb	1813	9	1822
Mar	1822	9	1831
Apr	1831	9	1840
May	1840	9	1849

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
Jun	1849	9	1858
Jul	1858	9	1867
Aug	1867	9	1876

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	Sep	
Phase-in/Phase-out begins	Sep	1
Phase-in/Phase-out ends	Aug	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 (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in 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:

Adult Group 42 CFR 435.119

Former Foster Care Group: Section 1902(a)(10)(A)(i)(IX) of the Act

Parents and Other Caretaker Relatives: 42 CFR 435.110

Pregnant women 42 CFR 435.116

Children 42 CFR 435.118

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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 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:

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: 1

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

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Qualifications for MA Medical Assistant Consultants include one of the following:

Medical Assistant Consultant

Requires knowledge, skill and mental development equivalent to completion of four years of college with licensure in one of the four specialties: Registered Nurse, Licensed Practical Nurse, Speech/Language Pathologist, Physical Therapist or Occupational Therapist. Requires three years professional experience in field related (mental and physical treatment of care). Requires extensive knowledge of social and medical treatment casework principles and techniques, federal, state, and local legislation and agency requirements pertinent to public assistance, medical care, and rehabilitation assistance. Requires working knowledge of social and medical social work literature, individual health, rehabilitation and educational needs and community and state resources. Requires ability to direct and give effective consultation and instruction related to professional medical services.

.

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

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

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

The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.

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

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

Hospitals:

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

Nursing Facilities:

In order to be eligible for waiver services, the customer must be evaluated with Illinois' nursing facility level of care assessment and receive at least the minimally required points established in rule. This assessment includes a mini-mental state examination (MMSE) and functional status section. The functional status section assesses both activities of daily living (ADL) and instrumental activities of daily living (IADL). When scoring the ADLs and the IADLs, the reviewer assesses both the level of impairment and the unmet need for care. The final score is calculated by adding the results of the MMSE, the level of impairment and the unmet need. State rules regarding prescreening are found in 89 Il Admin Code, Part 681. State rules pertaining to the DON are found in 89 Il Admin Code, part 679.

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

The same Illinois MFTD LOC instrument that is used for admission to the waiver is also used for reevaluations for continued eligibility. The OA initiates the process by collecting the medical documentation, completing the LOC and sending it to the MA for final review and approval. The LOC review is completed annually or when there is significant change in the customer's condition. The LOC is reviewed and approved by the MA including a review of waiver services utilized to determine the continued need for the waiver.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial

evaluations.

The qualifications are different.

Specify the qualifications:

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

The OA uses a report to track the timeliness of initial evaluations and re-evaluations. The report includes the date the LOC was completed, the registration date (physician information and insurance information obtained) and the date the waiver application was submitted to the MA. The OA Quality Improvement Team reviews and monitors the report on a daily basis to assure timelines are being met. When findings occur, the OA works with the care coordination regional office to identify the root cause and implement remediation to ensure timeliness of initial evaluations and re-evaluations. The OA shares the report with the MA at each Quarterly Management Meeting and findings/remediation are discussed.

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

Both the MA and the OA maintain evaluations and reevaluations. Prior to 2017, the MA stored hard copies of the applications/renewals at their office located at 607 East Adams Springfield, IL. Historical records still remain there at this time. In 2017, the MA transitioned to storing files electronically. Only staff working on the waiver have access to the secure electronic files.

The OA's files are stored electronically via their care coordination software, Client Track, which stores all assessment documentation. This software is backed up every night. Care Coordinator are located throughout the state in local OA offices and have access to the Client Track system at each OA office through secure log in restricted access.

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 a reasonable indication that services may be needed in the future who received a 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 a level of care assessment prior to receipt of services. D: Total number of applicants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA Report: Eligibility 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: 	

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 waiver customers reassessed, as specified in the approved waiver, through the redetermination process of waiver eligibility every 12 months. N: Number of waiver customers reassessed, as specified in the approved waiver, through the redetermination process of waiver eligibility every 12 months. D: Total Number of waiver customers who had reassessment due.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MA Reports: Eligibility Report

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

(check each that applies):		
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	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 LOC determinations and reevaluations completed for waiver customers using the processes and instruments described in the approved waiver. N: Number of LOC determinations and reevaluations completed for waiver customers using the processes and instruments described in the approved waiver. D: Total number of LOC determinations and reevaluations completed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MA Reports: Eligibility 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: 	

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:

- 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 OA reviews and reports data on a quarterly basis. This performance data is then presented by OA Quality staff to the Regional Care Coordination Teams through a post-review discussion which focuses on strengths, root cause, patterns and

trends, and compliance. At the time of the post review discussion all findings are shared and timelines for remediation are initiated. Systemic issues are discussed with input from regional teams on causes and resolutions.

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, correction of billing and claims; 4. Individual staff training as appropriate; Remediation must be completed within 60 days.

B2: 1. LOC is completed/corrected upon discovery; 2. If eligible, no additional correction required; 3. If ineligible, billing and claims adjusted; 4. Customer receives assistance with accessing other supports and services; Remediation must be within 60 days.

B3: If it is discovered that the LOC score does not support LOC determination, the MA will complete a plan of correction to include a reassessment or justification if in error. If the justification is inadequate and/or the reassessment does not result in the required scoring, the waiver eligibility will be discontinued and the OA will assist the customer with accessing other supports and services. Federal claims will be adjusted and the MA will provide technical assistance or training. Remediation must be completed 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: 	Annually
	Continuously and Ongoing
	Other Specify:

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Parents or guardians are informed of feasible alternatives and given a choice of waiver services or institutional care. The information is provided by the OA enrollment specialist at the earliest time during the hospital discharge planning process, or in the customer's home. It is explained again annually. The final choice made by the parents or guardian is documented on the choice form and is signed by the customer's parents/guardian and the OA enrollment specialist or Care Coordinator. The form documents whether the family chooses in home or institutional services.

The signed form also indicates that the family is expected to provide, to the fullest extent possible, direct care to the customer receiving services and that the services approved through the waiver may be revised based on periodic reviews and changes in the medical and home environment needs of the customer.

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

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

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

Electronic copies of freedom of choice forms are maintained indefinitely in the customer's electronic case record in the OA's electronic case management system.

Appendix B: Participant Access and Eligibility

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

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

In addition to the assistance provided by the OA for accessing care coordination services through the OA regional offices, the Care Coordinators assist the families to access nursing and waiver services through the same strategies using bilingual OA staff, bilingual community interpreters, and the State's contracted language line. Potential service providers are apprised of the need to use interpreters or their own bilingual staff for those families with limited English proficiency. The OA also assists the families in determining the ability of the potential providers in meeting that need. The OA agency has all written forms available in Spanish. The OA agency also contracts with a translation company to translate any forms, service plans, etc. into any language upon request of the customer or family.

Appendix C: Participant Services

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

Service Type	Service		
Statutory Service	Respite		
Other Service	Adaptive Equipment		
Other Service	Assessment by Occupational or Physical Therapist		
Other Service	Assistive Technology		
Other Service	Certified Nursing Assistant (CNA)		
Other Service	Environmental Accessibility Adaptations		
Other Service	Family Training		
Other Service	Home Accessibility Modifications		
Other Service	In-Home Shift Nursing		
Other Service	Nurse Training		
Other Service	Pest Control		
Other Service	Placement Maintenance Counseling Services		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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

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

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

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

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

Respite care services will be limited to a maximum of 14 days or 336 hour annual limit. Exceptions may be made on an individual basis based on extraordinary circumstances. Legally responsible persons or legal guardians living within the same household of the participant may not provide respite services.

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	Children's Community-Based Health Care Center
Agency	Approved Nursing Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Children's Community-Based Health Care Center

Provider Qualifications**License (specify):**

77 ILAC 260

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

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

Be in good standing in accordance with OA policy.

Enrolled Vendor in Impact and active with State Comptroller. Approved by the OA, customer and family.

Verification of Provider Qualifications**Entity Responsible for Verification:**

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

The Department of Public Health (DPH) licenses the model.

Frequency of Verification:

The OA verifies annually.

The DPH verifies annually.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Approved Nursing Agency

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Meet requirements for Nursing Agencies participating with the Medicaid Agency and the DSCC Home Care Program.

Be in good standing in accordance with OA policy.

Enrolled with the Medicaid Agency's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system, be active with State Comptroller, and approved by the OA, customer and family.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The OA

Frequency of Verification:

Upon enrollment and annually

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adaptive Equipment

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Adaptive equipment, as specified in the PCP, includes (a) devices, controls, or appliances that enable customers to increase or maintain their ability to perform activities of daily living; and (b) devices, controls or appliances that enable customers to perceive, control, access or communicate with the environment in which they live. This service is subject to prior approval by the OA.

All items shall meet applicable standards of manufacture, design, and installation. All purchased items shall be the property of the customer or the customer's family.

Items and/or modifications available through the waiver are:

- Weighted blankets or vest
- Noise cancelling headphones, electronic devices, specialized computer/communication software, and communication devices.
- Sensory swing, sensory items, wrist weights, grabbers, and reachers.
- Mats, wedges, or positioning items, lift chair mechanisms, and mobility devices.
- Cost for consultation, installation, set-up and/or training to use adaptive equipment are allowable when specified as part of the funding request.

Amendment IL.0278.R06.03, effective 7/1/2026 or upon CMS approval

Adding additional items:

- Standers, adaptive car seats, adaptive swings, adaptive bicycles, adaptive stroller, bath/shower chair
- Electric Hoyer Lift, fall recovery, and mobility aids
- Adaptive utensils, cookware, and dishes
- Trampoline, sensory floor mats

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

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	Equipment Vendors

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adaptive Equipment

Provider Category:

Agency

Provider Type:

Equipment Vendors

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Be in good standing in accordance with OA policy.

Enrolled with the Medicaid Agency's Illinois Medicaid Program Advanced Cloud

Technology (IMPACT) system, be active with State Comptroller, and approved by the OA, customer and family.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Upon enrollment

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:

Assessment by Occupational or Physical Therapist

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

17 Other Services

Sub-Category 2:

17990 other

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

An assessment by an occupational or physical therapist to evaluate the physical and family environment with the purpose of ensuring the living conditions are suitable for the customer's medical and functional needs. The designated healthcare professional will perform a home visit to customer's home and will focus on the following:

1. Inspecting various aspects of the home, including accessibility, safety, and the ability for customer to live with as much independence as possible.
2. Discussing customer's medical needs, functional needs, and daily routine for customer, family and paid staff.
3. Recommending improvements or modifications to the home or customer's environment—including home modifications, adaptive equipment and assistive technology.

Benefits of this service include:

- Enhanced safety and comfort at home.
- Improved management of medical conditions in a home setting.
- Enhanced quality of life and increased independence in daily activities.

This service is subject to prior approval by the OA.

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

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

Participant-directed as specified in Appendix E

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
Individual	Physical Therapist
Individual	Occupational Therapist
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assessment by Occupational or Physical Therapist

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License (*specify*):

225 ILCS 90

Certificate (*specify*):

Other Standard (*specify*):

Be in good standing in accordance with OA policy.

Enrolled with the Medicaid agency's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system, be active with State Comptroller, and approved by the OA, customer, and family.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

Initially and annually

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Assessment by Occupational or Physical Therapist**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Assessment by Occupational or Physical Therapist**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

Frequency of Verification:

Initially and annually

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Assistive technology is an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of customers. This service is subject to prior approval by the OA. This service does not include assistive technology provided under EPSDT.

The need for assistive technology must be included in the PCP. Assistive technology includes:

- Services consisting of purchasing or otherwise providing for the acquisition of assistive technology devices for the customer.
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
- Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the PCP.
- Training or technical assistance for the customer, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the customer.
- Training or technical assistance for professionals or other persons who provide services to, employ, or are otherwise substantially involved in the major life functions of the customer.

All items shall meet applicable standards of manufacture, design, and installation. All purchased items shall be the property of the customer or the customer's family.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

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	Equipment Vendors

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Equipment Vendors

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Be in good standing in accordance with OA policy.

Be enrolled with the Medicaid Agency's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system, be active with State Comptroller, and approved by the OA, customer and family.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Certified Nursing Assistant (CNA)

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08020 home health aide

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

The Certified Nursing Assistant (CNA) service is an extended State Plan version of the "Home Health Aide" service in the State Plan and on the HFS Fee Schedule for Home Health Nursing Agencies. Services provided through the State Plan are provided on a short-term or intermittent basis. These services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State Plan services are provided to facilitate and support the customer in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan the first 60 days following discharge from a hospital or long term care facility do not require prior approval when services are initiated within 14 days of discharge. Home Health Aides in the State Plan are paid per visit; rather than hourly. Visits are limited to two hours or less.

Home Health Aide services, under the waiver are paid hourly and may be provided when the customer does not meet the prior approval requirements for the State Plan services. Home Health Aide services through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Services are provided by an individual that meets Illinois standards for a Certified Nursing Assistant (CNA) and provides services as defined in 42 CFR 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid state plan shall not be applicable. Specific tasks follow:

Home Health Aides may provide basic services to persons, assisting with the assessment and care planning, nutrition and elimination needs, mobility, personal hygiene and grooming, comfort and anxiety relief, promoting customer safety and environmental cleanliness. Home Health Aide duties include: checking and recording vital signs, measuring height and weight, measuring intake and output, collecting specimens, feeding, assisting with bed pans, assisting with colostomy care, turning and positioning, transferring to wheelchairs/stretchers, bathing, assisting with oral hygiene, shaving, preparing hot and cold applications, making beds, observing response to care, reporting and recording observations of person's condition, cleaning and caring for equipment, and transporting.

This waiver service is only provided to customers ages 21 and over. All medically necessary certified nursing assistant services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

CNA services require an order from a physician stating that the customer requires CNA services in the home. Other documents required include: medical reports, and reports of hospitalizations. The amount, duration and/or frequency of these services are dependent on continued authorization by the physician, and an independent assessment of medical necessity by the MA or its designee.

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

CNA services require a prescription from a physician stating that the individual requires CNA services in the home. Other documents required include: medical reports, and reports of hospitalizations. The amount, duration and/or frequency of these services are dependent on continued authorization by the physician, and an independent assessment of medical necessity by the Medicaid agency or its designee.

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

Participant-directed as specified in Appendix E

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	DSCC Approved Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Certified Nursing Assistant (CNA)

Provider Category:

Agency

Provider Type:

DSCC Approved Nursing Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Meet requirements for Nursing Agencies participating with the Medicaid Agency and the DSCC Home Care Program.

Be in good standing in accordance with OA policy.

The vendor must be enrolled with the Medicaid Agency's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system, be active with State Comptroller, and approved by the OA, customer and family.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OA

Frequency of Verification:

Upon enrollment and annually

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

EFFECTIVE 1/1/2025 per IL.0278.R06.02, Environmental Accessibility Adaptations is no longer a waiver service. The services previously grouped under the Environmental Accessibility Adaptations service umbrella are now separate services. The new separate services include:

- Pest Control
- Home Accessibility Modifications
- Vehicle Modifications

Those physical adaptations to the home or family vehicle required by the customer's plan of care, which are necessary to ensure the health, welfare and safety of the customer, or which enable the customer to function with greater independence in the home or community, and without which, the customer would require institutionalization. Such adaptations may include the following: telephone installation; exterminations of disease vectors; minor carpentry around windows and doors to reduce drafts; house lifts (in those situations where a ramp is not possible) the installation of ramps and grab-bars; widening

of doorways; modifications of bathroom facilities; installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the customer; professional electrical assessments to ensure that the customers who have medical equipment that requires electricity can safely operate in the home, generator purchase and/or repair.

Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning. Adaptations, which add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate mobility equipment). All services shall be provided in accordance with applicable State or local building codes.

The State assures that all Environmental Accessibility Adaptations will only be provided to meet the medical necessity of the participant. They will also be limited in scope to the minimum necessary to meet the participant's medical needs. This service is not otherwise covered in the State Plan.

The services under the Environmental Accessibility Adaptations service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

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
Individual	Contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Contractor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Be in good standing in accordance with OA policy.

The OA's DSCC Home Care Manual, 53.20.30, (Rev.9/01) & 53.43 (Rev.9/01)

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Training

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

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
Individual	Approved Service Agency
Agency	OA Approved Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Training

Provider Category:

Individual

Provider Type:

Approved Service Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Be in good standing in accordance with OA policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OA

Frequency of Verification:

At time of service

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Training

Provider Category:

Agency

Provider Type:

OA Approved Nursing Agency

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Meet requirements for Nursing Agencies participating with the Medicaid Agency and the DSCC Home Care Program.

Be in good standing in accordance with OA policy.

Enrolled with the Medicaid Agency's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system, be active with State Comptroller, and approved by the OA, customer and family.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The OA

Frequency of Verification:

Upon enrollment and annually

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Accessibility Modifications

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:**

Category 4:**Sub-Category 4:****Service Definition (Scope):**

Those physical adaptations to the private residence of the customer, required by the customer's PCP, which are necessary to ensure the health, safety, and welfare of the customer or enable the customer to function with greater independence in the home. A private residence may encompass more than one residence when there is a shared custody arrangement involving joint legal and physical custody. This service is subject to prior approval by the OA.

Such modifications may be made while the customer is institutionalized. Home Accessibility Modifications must be included in the customer's PCP and may be furnished up to 180 consecutive days prior to the customer's discharge from an institution. However, such modifications will not be considered complete until the date the customer leaves the institution and is enrolled in the waiver. In the event the customer dies before going home (or is determined to be unable to go home) after the expenses have been incurred, the State will claim these expenses as administrative costs at the administrative FFP rate for services which would have been necessary for relocation to have taken place when the customer has applied for waiver service; and has been found eligible for the waiver by the State but died or was determined unable to go home, before the actual delivery of the waiver service.

Home accessibility modifications may be either permanent or not permanent. Permanent home modifications are either structural modifications or items attached to the home. Examples of home accessibility modifications include:

- Ramps, house lifts, overhead lifts, or elevators necessary to enter or leave the home or to access a bedroom or a bathroom, including porch or stair lifts and hydraulic, manual, or electric lifts.
- Bathroom modifications, including roll-in showers, sink modifications, bathtub modifications, toilet modifications, grab bars, adapted water faucet controls, floor urinal and bidet adaptations, plumbing modifications, and turnaround space adaptations.
- Widening of doorways/hallways (may include minimally necessary floor covering to cover the new floor area).
- Specialized accessibility/safety adaptations/additions including grab bars; necessary handrails beyond those normally required by building codes; lowered or adaptive door handles; adapted fire alarms, sprinklers, smoke detectors, and doorbells; automatic door openers/doorbells voice-activated, light-activated, motion-activated, and electronically activated devices; fire safety adaptations; and electrical wiring associated with the above.
- Specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.
- Professional electrical assessments to ensure that the customers who have medical equipment that requires electricity can safely operate in the home.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the customer. Examples of items not covered under home modifications include:

- Cosmetic refurbishment.
- Items that add value to the home.
- Roof repair.
- Installation or repair of furnace/air conditioning.
- Installation of hot tubs, spas, whirlpool tubs, saunas, and replacing an existing tub with a new tub.
- Room renovation, exterior renovation, or renovations to a porch or deck.
- Adaptations that add to the total square footage of the home.
- Seasonal items such as swimming pools and related equipment.
- Modifications to basements or attics are not included, due to safety concerns, egress concerns, and potential isolation from the rest of the family.
- Fencing, unless elopement behavior is present and cannot be addressed in other ways.

Amendment IL.0278.R06.03 effective 7/1/2026, or upon CMS approval

- Add Installation of Generators as a covered service, in addition to purchase or repair as above.
- Add Orbit lifts and stair lifts to the list of examples of home accessibility modifications
- Revise the 1st dot point of the 3rd paragraph above (regarding Ramps, lifts, or elevators) to delete the verbiage "access a bedroom or bathroom" and replace with "access areas within the home". The revised dot point is as follows: Ramps, house lifts, overhead lifts, or elevators necessary to enter or leave the home or to access any area within the home, including porch or stair lifts and hydraulic, manual, or electric lifts.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

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
Individual	Contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Accessibility Modifications

Provider Category:

Individual

Provider Type:

Contractor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Be in good standing in accordance with OA policy.

Enrolled Vendor in IMPACT, the Medicaid provider enrollment system. Certified and active with the Illinois State Comptroller. In addition, be approved and by the OA, customer and family.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Upon enrollment

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:

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:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

The waiver provides in-home shift nursing to adults (age 21 and over) as this service is not covered in the Illinois State Plan. In-home shift nursing is different than intermittent nursing because customers require hourly shift nursing rather than an intermittent visit, to perform a specific task. These services are provided by RNs and LPNs that meet Illinois licensure standards for nursing services. RNs and LPNs may only provide services authorized through their licensure type. Services may include the following.

Registered Nurses may provide and coordinate care, educate the customer and the public about various health conditions, and provide advice and emotional support. Registered Nurses duties may also include recording medical histories and symptoms, administering medications and treatments, developing the nursing plan of care or contributing to existing plans, observing and recording findings, consulting with doctors and other healthcare professionals, operating and monitoring medical equipment, assisting in the performance of diagnostic tests, analyzing the results, teaching how to manage illnesses or injuries, as well as explaining at home treatment options.

Licensed Practical Nurses provide basic medical care, under the direction of registered nurses and doctors. LPN's duties may include but are not limited to administering basic nursing care, monitoring health by checking blood pressure, changing bandages, inserting catheters, providing basic comfort, including bathing and dressing, as well as discussing health care with the customers and families, addressing concerns, while keeping adequate records regarding health, and reporting pertinent information to registered nurses and physicians.

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

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

In-home shift nursing services require a prescription from a physician stating that the individual requires shift nursing services in the home. Other documents required include: medical reports, and reports of hospitalizations. The amount, duration and/or frequency of these services are dependent on continued authorization by the physician, and an independent

assessment of medical necessity by the Medicaid agency or its designee.

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

Participant-directed as specified in Appendix E

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	DSCC Approved Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: In-Home Shift Nursing

Provider Category:

Agency

Provider Type:

DSCC Approved Nursing Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Meet requirements for Nursing Agencies participating with the Medicaid Agency and the DSCC Home Care Program.

Be in good standing in accordance with OA policy.

Enrolled with the Medicaid Agency's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system, be active with State Comptroller, and approved by the OA, customer and family.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nurse Training

HCBS Taxonomy:**Category 1:**

05 Nursing

Sub-Category 1:

05010 private duty nursing

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

This service provides customer specific training for nurses, under an approved nursing agency, in the use of new or unique prescribed equipment, or special care needs of the customer. This service is not covered in the State Plan.

This service does not have an age limit and it is available to all customers.

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

Maximum of thirty-two hours per nurse, per child, per waiver year.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

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	OA Approved Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nurse Training

Provider Category:

Agency

Provider Type:

OA Approved Nursing Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Meet requirements for Nursing Agencies participating with the Medicaid Agency and the DSCC Home Care Program.

Be in good standing in accordance with OA policy.

Be enrolled with the Medicaid Agency's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system, be active with State Comptroller, and approved by the OA, customer and family.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Pest Control

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Pest Control Service is the chemical or physical eradication of pests by a professional in a waiver customer's primary residence, the presence of which may limit or prevent the service providers from entering the setting to deliver other critical waiver services or result in potential health related issues for the customer.

Pest Control services include the following activities: (a) assessment or inspection, (b) application of chemical-based pesticide, (c) setting of traps, and (c) follow up visit.

Pest control services may be provided in a waiver customer's primary residence, which is limited to a customer living with a primary caregiver or a customer living in his/her own private house or apartment and who is responsible for his/her own rent or mortgage.

Pest control services may be made while the customer is institutionalized. Pest control services, included in the customer's PCP, may be furnished up to 180 consecutive days prior to the customer's discharge from the institution. However, such services will not be considered complete until the date the customer is enrolled in the waiver. In the event the customer dies before going home (or is determined to be unable to go home) after the expenses have been incurred, the State will claim these expenses as administrative costs at the administrative FFP rate for services which would have been necessary for relocation to have taken place when the customer has applied for waiver service; and has been found eligible for the waiver by the State but died or was determined unable to go home, before the actual delivery of the waiver service.

This service is subject to post approval by the OA. The MA and OA chose to allow for post approval due to emergent need to rid vermin for this medically complex population. Additional treatments may be approved if the lack of such treatments would jeopardize the customer's ability to live in the community. If additional treatments are needed, the State will evaluate that customer's living situation to determine if the community arrangement is appropriate and supports their health and safety.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:**Service Delivery Method (check each that applies):**

Participant-directed as specified in Appendix E

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
Individual	

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Pest Control****Provider Category:**

Individual

Provider Type:

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Be in good standing in accordance with OA policy.

The vendor must be enrolled with the Medicaid Agency's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system, be active with State Comptroller, and approved by the OA, customer and family.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OA

Frequency of Verification:

Upon enrollment.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Placement Maintenance Counseling Services

HCBS Taxonomy:

Category 1:**Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Amendment IL.0278.R06.03, effective 7/1/2026 or upon CMS Approval

Placement Maintenance Counseling is being removed as a waiver service as it is not necessary. Placement Maintenance Counseling is covered under EPSDT and/or the Medicaid State Plan.

This service provides short-term, issue-specific family or customer counseling for the purpose of maintaining the participant in the home placement. This service is prescribed by a physician based upon his or her judgment that it is necessary to maintain the child in the home placement. This service must be provided by a licensed clinical social worker (LCSW), a licensed clinical psychologist (LCP), a licensed clinical professional counselor (LCPC) or an agency certified by the Department of Human Services, Division of Mental Health or Department of Children and Family Services to provide Medicaid Rehabilitation Option services. The service provider must accept MA payment, as payment in full, and provide services in the home if the participant or participant's family is unable to access services outside the home. This service is not covered in the State Plan.

The services under the Placement Maintenance Counseling Services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

This service does not have an age limit and it is available to all customers.

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

Services will require prior approval by the OA and will be limited to a maximum of twelve sessions per calendar year.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

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
Individual	Licensed Clinical Psychologist
Agency	Medicaid Rehabilitation Option
Individual	Licensed Clinical Social Worker

Provider Category	Provider Type Title
Individual	Licensed Clinical Professional Counselor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Placement Maintenance Counseling Services

Provider Category:

Individual

Provider Type:

Licensed Clinical Psychologist

Provider Qualifications

License (specify):

225 ILCS 15

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Upon enrollment for each service

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Placement Maintenance Counseling Services

Provider Category:

Agency

Provider Type:

Medicaid Rehabilitation Option

Provider Qualifications

License (specify):

59 IL Admin Code Part 132 MRO

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Upon enrollment for each service

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Placement Maintenance Counseling Services****Provider Category:**

Individual

Provider Type:

Licensed Clinical Social Worker

Provider Qualifications**License (specify):**

225 ILCS 20

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

OA

Frequency of Verification:

Upon enrollment for each service

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Placement Maintenance Counseling Services****Provider Category:**

Individual

Provider Type:

Licensed Clinical Professional Counselor

Provider Qualifications**License (specify):**

225 ILCS 107

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications**

Entity Responsible for Verification:

OA

Frequency of Verification:

Upon enrollment for each service

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Amendment IL.0278.R06.03, effective 7/1/2026 or upon CMS Approval

Specialized Medical Equipment is being removed as a waiver service as it is not necessary. All equipment or supplies needed to maintain a customer in the home and the coverage of operational and maintenance costs of equipment are available through EPSDT and/or the Medicaid State Plan or under Adaptive Equipment and Assistive Technology.

This service is the provision of equipment or supplies needed to maintain a customer in the home and the coverage of operational and maintenance costs of equipment, not otherwise available through the State Plan or through other third-party liability.

Medical supplies, equipment and appliances are provided only on the prescription of the primary care physician as specified in PCP. Since each home care waiver case addresses a unique set of needs, provision of an all-inclusive list is not possible. Therefore, the State assures that these services will only be provided to meet the medical, health and safety needs of the

customer. These will be limited in scope to the minimum necessary to meet the customer's needs and will be utilized in accordance with manufacturer's suggested standards.

This service differs from that offered under the State Plan in that it includes operational and maintenance costs for equipment. (Maintenance costs are incurred only for Medicaid agency leased or family-owned equipment not otherwise available under the State Plan.)

This waiver service is only provided to customers ages 21 and over. All medically necessary specialized medical equipment and supplies services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

The approval for this service is subject to prior approval by the OA.

Effective 07/01/26 per IL 0278.R06.03, this is no longer a service.

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

There is for pest a \$25,000 maximum over 5 years, per customer for pest control, adaptive equipment, assistive technology, home modifications, vehicle modifications, and power generators.

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	Other Medicaid Provider
Agency	Approved Medicaid Medical Equipment or Infusion Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Other Medicaid Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

A Medicaid enrolled pharmacy or durable medical equipment provider that provides items not available from the OA approved Home Medical Equipment Provider (such as formula).

Enrolled vendor in Impact and active with State Comptroller. Approved by the OA, customer and family.

Verification of Provider Qualifications
Entity Responsible for Verification:

The OA

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies
Provider Category:

Agency

Provider Type:

Approved Medicaid Medical Equipment or Infusion Provider

Provider Qualifications
License (specify):

225 ILCS 51

Certificate (specify):
Other Standard (specify):

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

The vendor must be enrolled with the Medicaid Agency's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system, be active with State Comptroller, and approved by the OA, customer and family.

Verification of Provider Qualifications
Entity Responsible for Verification:

The OA

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: 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:

Vehicle Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Vehicle modification includes adaptations or alterations to a vehicle that is the customer's primary means of transportation to accommodate the special needs of the customer. The family with whom the customer lives must own the vehicle that is adapted. Vehicle modifications must be specified by the PCP as necessary to enable the customer to integrate more fully into the community and to ensure the health, welfare, and safety of the customer. This service is subject to prior approval by the OA.

Such modifications may be made while the customer is institutionalized. Vehicle modifications, included in the customer's PCP, may be furnished up to 180 consecutive days prior to the customer's discharge from an institution. However, such modifications will not be considered complete until the date the customer leaves the institution and is enrolled in the waiver. In the event the customer dies before going home (or is determined to be unable to go home) after the expenses have been incurred, the State will claim these expenses as administrative costs at the administrative FFP rate for services which would have been necessary for relocation to have taken place when the customer has applied for waiver service; and has been found eligible for the waiver by the State but died or was determined unable to go home, before the actual delivery of the waiver service.

The following are specifically excluded:

- Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the customer.
- Purchase or lease of a vehicle.
- Scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

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	Equipment Vendor and Installer

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Vehicle Modifications****Provider Category:**

Agency

Provider Type:

Equipment Vendor and Installer

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Be in good standing in accordance with OA policy.

Enrolled with the Medicaid Agency's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system, be active with State Comptroller, and approved by the OA, customer and family.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OA

Frequency of Verification:

Upon enrollment

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:

OA Care Coordinators conduct case management functions on behalf of waiver customers. The MA has designated the OA as the care coordination entity for the State's Home Care Program. The Home Care Program serves both waiver and non-waiver customers that require in-home shift nursing services.

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

- 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;

Nursing agencies and Children's Community-Based Health Care Centers are responsible, under a signed agreement with the OA, for complying with the Health Care Worker Background Check Act. The Act requires that the agencies cannot knowingly hire persons in the position of providing direct care who have a history of criminal conviction for specified crimes as listed in the Act. This includes nurses and certified nurse aides.

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

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

Agencies cannot knowingly hire a nurse or a CNA who has a disqualifying disciplinary action with the Illinois Department of Financial and Professional Regulation (IDFPR).

The OA requires that all individuals who are offered employment positions undergo criminal background checks and other pre-employment assessments. The OA reserves the right to withdraw or rescind any offer of employment to any individual who cannot successfully complete the background checks and other pre-employment assessments required of the position. Background checks will be performed in compliance with the Fair Credit Reporting Act.

The OA's background checks are completed by a third-party vendor and include:

- National, state, and county criminal records
- National and state Sex Offender Registries (SOR)
- Social Security Number verification

If a felony offense within the industry standard timeframe is found, the offer would be rescinded. Misdemeanor offenses are reviewed on a case-by-case basis. Any offense related to violence or that could pose any threat to the health and safety of the customers would also result in rescindment of the employment offer. Any finding would be made known to the OA leadership who would consult with MA if needed.

(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);

During the annual Nursing Agency review, verification will be made to ensure that each nurse selected in the sample, has documentation of a check of the Illinois Department of Children and Family Services (DCFS) Child Abuse and Neglect Tracking System (CANTS). During this review, each nurse's license will be checked with IDFPR to ensure the existence of no disqualifying circumstances. On an annual basis, the OA completes a review of the Healthcare and Family Services Office of Inspector General provider Sanction list and the Department of Health and Human Services OIG Exclusion Data base.

The OA also verifies during the annual nursing agency reviews that a criminal background check was done for CNAs providing care for customers selected in the sample.

The Medicaid Agency (MA) initiated a provider enrollment system in Fiscal Year 2016 in response to requirements of the Affordable Care Act. The Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system is a web-based system designed to improve provider access, and to ensure customers receive timely and high-quality Medicaid services, including services provided to Medicaid waiver customers. Providers must be enrolled in the IMPACT system prior to being reimbursed for services. Background checks are completed on each provider during the enrollment process. Providers must meet all qualifications and pass all screening checks to be approved and entered in IMPACT. A provider cannot be enrolled and serve Medicaid customers unless all mandatory screenings have been conducted. Providers must meet all qualifications and pass all screening checks to be approved and entered in IMPACT (HFS Inspector General's Office, the Illinois Department of Public Health's Health Care Worker Registry, a Healthcare Worker Background Check, the Illinois Department of Professional and Financial Regulation registry, etc.). The IMPACT system allows the MA to ensure 100% of licensed or certified providers continue to meet the required standards by performing automatic checks of the IL Department of Financial and

Professional Regulation's licensure and certification database and exclusion databases. If a provider has a termination or lapse in licensure or certification or appears on an exclusion database, the MA will disenroll the provider and notify the OA. The waiver customer is notified, and a different provider is selected. To ensure an adequate network, both the MA and OA work with providers to correct any lapse in licensure or certification and to troubleshoot any issues with enrollment to regain approved provider status. Both the MA and OA monitor network capacity to ensure an adequate network.

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;

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

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

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

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

(c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law 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 shift nursing and CNA waiver services when employed by a Home Nursing Agency approved by the MA and OA. Relatives/legal guardians employed by a Home Nursing Agency approved by the MA and OA, may be paid for providing respite services if they do not live/reside in the same home as the customer lives. The Home Nursing Agency is responsible for hiring, scheduling, supervising, and monitoring. The relative or legal guardian must meet the same criteria and qualifications as any other nurse or CNA employee. Services must be provided under a physician's prescription as well as a Person-Centered Plan. The Home Nursing Agency conducts onsite supervisory visits every 60 days for both in-home shift nurses and CNAs. During the supervisory visit, the customer's general condition and home environment will be assessed to ensure services are being provided in accordance with the customer's PCP and to ensure that payments are made only for services rendered. Prior to the legally responsible adult providing service, the Care Coordinator will discuss with the customer/family that there are no other viable service/provider alternatives and document this in the customer record.

Limits apply to shift nursing, respite, and CNA waiver services. A legally responsible individual, relative, or legal guardian may not work more than 16 hours/day, with 8-hour break in between shifts. Services must not exceed the monthly allocation for nursing services.

Specific requirements for paying legally responsible relatives follow:

- The customer must be 21 years of age or older.
- The paid legally responsible caregiver must be a registered nurse, or a licensed practical nurse and in good standing with the Illinois Department of Financial and Professional Regulations and Department of Health and Human Services.
- For CNAs, the paid legally responsible caregiver must have completed the State approved Home Health Aide Training and be certified as a nurses' aide with the Illinois Department of Public Health.
- The paid legally responsible caregiver must be employed and supervised by a nursing agency enrolled with the MA and assigned to staff the case.
- The paid legally responsible paid caregiver must comply with all the nursing agency's policies, procedures, and documentation requirements.
- The paid nursing agency must develop and document additional assurances and monitoring oversight to ensure that an appropriate back-up coverage plan is in place and such plan must include unpaid trained caregivers.
- Respite may only be provided by a legally responsible person or a legal guardian when that person lives in a separate household.

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

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

Other policy.

Specify:

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

Any willing and qualified provider may request to be enrolled in the waiver program. Providers may contact the OA through any of their offices or go through the OA web site (<https://dscc.uic.edu/for-providers/provider-criteria-2/>) to request information about the requirements and procedures to qualify. There are no specific timeframes for qualifying or enrolling.

Providers enter the program in a number of ways:

- Provider may contact the OA regional office or go through the OA website. (<https://dscc.uic.edu/for-providers/provider-criteria-2/>)
- Family may request a specific provider. The family may already be working with a nursing agency or home medical supplier, or they may request a specific provider.
- The OA regional office may recruit nursing agencies, home medical equipment providers or other providers.

Approved Nursing Agency;

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

For those agencies indicating an interest in becoming an approved nursing agency, an OA representative will complete a follow-up review to ensure the agency meets the needed requirements. Upon assurance that the agency has met the required standards, OA staff are then assigned the responsibility of meeting with the nursing agency administrative personnel to explain the Home Care program.

The OA provides the nursing agency a copy of the participation requirements and completes an interview questionnaire with the agency. The OA also sends an approval packet to the agency that requests the required documents, including evidence of license and professional insurance, and provides Medicaid enrollment forms if not already enrolled.

Upon approval, the OA sends a notification of approval to the agency and updates all the Home Care regional offices.

Home Medical Equipment (HME) Providers;

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

Upon approval, the OA sends a notification of approval to the HME provider and updates all the Home Care regional offices.

Other Providers:

Families or care coordinators can identify other provider of services, including: adaptive equipment, assistive technology, home accessibility modifications, vehicle modifications, and pest control. The home accessibility modifications may include electrical modifications, providers that install lifts or ramps, or carpenters that widen doorways. The providers are responsible for obtaining appropriate permits and submitting their bill to the care coordinator. The provider must be enrolled and provide tax identification information and proof of insurance.

Any interested provider can contact the OA through any of their offices or the OA web site (<https://dscc.uic.edu/for-providers/provider-criteria-2/>) to request information about the requirements and procedures to qualify. There are no specific time frames for qualifying or enrolling. Providers must be enrolled in the Medicaid program and meet the requirements for participation.

The State re-approves enrolled providers annually and enrolls new providers on an ongoing continuous basis. The State works with new providers to assure state standards and requirements are met. Once all requirements appear to be met new agencies will be reviewed and approved within 30 days.

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 licensed/certified waiver service providers who meet provider requirements in the approved waiver prior to providing waiver services. N: Number of newly enrolled licensed/certified waiver service providers who meet provider requirements in the approved waiver prior to providing waiver services. D: Total number of newly enrolled licensed/certified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA Reports

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

Data Aggregation and Analysis:

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

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:

C2: Number and percent of enrolled lic/cert waiver service providers who continue to meet provider requirements in the approved waiver prior to continuing to provide waiver services. N: Number of enrolled lic/cert waiver service providers who continue to meet provider requirements in the approved waiver prior to continuing to provide waiver services. D: Total number of enrolled lic/cert providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA Reports

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

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

C3: Number and percent of newly enrolled non-lic/non-cert waiver service providers who meet provider requirements in the approved waiver prior to providing waiver services. N: Number of newly enrolled non-lic/non-cert waiver service providers who meet provider requirements in the approved waiver prior to providing waiver services. D: Total number of newly enrolled non-lic/non-cert waiver providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA Reports

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <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:

C4: # and % of enrolled non-lic/non-cert waiver service providers who cont. to meet provider reqs in the approved waiver prior to continuing to provide waiver services.
N: # of enrolled non-lic/non-cert waiver service providers who cont. to meet provider reqs in the approved waiver prior to continuing to provide waiver services. **D:** Total # of enrolled non-lic/non-cert waiver service providers.

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

If 'Other' is selected, specify:

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

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

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

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

Performance Measure:

C5: # and % of newly enrolled RNs, LPNs, and CNAs who receive training in accordance with state requirements and the approved waiver prior to providing waiver services. N: # of newly enrolled RNs, LPNs, and CNAs who receive training in accordance with state requirements and the approved waiver prior to providing waiver services. D: Total # of newly enrolled RNs, LPNs, and CNAs.

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: 	

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:

C6: Number and percent of RNs, LPNs, and CNAs who receive training in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. N: Number of RNs, LPNs, and CNAs who receive training in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. D: Total number of RNs, LPNs, and CNAs.

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
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

C7: Number and percent of new OA Care Coordinators who meet training requirements in accordance with state requirements and the approved waiver prior to providing waiver services. N: Number of new OA Care Coordinators who meet training requirements in accordance with state requirements and the approved waiver prior to providing waiver services D: Total number of new OA Care Coordinators.

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: 	

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

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:

C8: Number and percent of OA Care Coordinators who continue to meet training reqs in accordance with state reqs and the approved waiver prior to continuing to provide waiver services. N: Number of OA Care Coordinators who continue to meet training reqs in accordance with state reqs and the approved waiver prior to continuing to provide waiver services. D: Total number of OA Care Coordinators.

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: 	

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:

- 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 MA has developed queries within its 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 Program Advanced 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.

The OA conducts comprehensive focused reviews using a statewide sample of customer records. PCP implementation and satisfaction are monitored during these reviews. The MA submits findings from routine monitoring to the OA for follow-up and correction.

The MA and OA meet quarterly to discuss summary reports that include statewide data and corrective action that has been

taken by the OA. This provides an opportunity for both agencies to identify trends and issues, and to discuss remediation steps.

The MA conducts routine programmatic and fiscal monitoring for the OA. 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 OA's sampling methodology is based on a statistically valid sampling methodology using a 95% confidence level and a +/-5% margin of error. The MA will pull the sample annually.

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 waiver licensed/certified waiver service provider fails initial IMPACT provider requirements, the MA informs provider of disposition of application and does not enroll into the Medicaid system. OA is also notified of findings.

C2: If an existing licensed/certified waiver service provider fails monthly screening by MA or Medicaid provider revalidation, the MA notifies provider and OA of the results and disenrolls provider.

C3: If a newly non-licensed/non-certified waiver service provider fails initial IMPACT screening requirements, the MA informs provider of disposition of application and does not enroll into the Medicaid system. OA is also notified of findings.

C4: If an existing non-licensed/non-certified waiver service provider fails monthly screening by MA or Medicaid provider revalidation, the MA notifies provider and OA of the results and disenrolls provider.

C5: The training requirements will be completed. The OA may require a plan of correction from the nursing provider for how training requirements will continually be met for all nurses. Remediation within 60 days.

C6: The training requirements will be completed. The OA may require a plan of correction from the nursing provider for how training requirements will continually be met for all nurses. Remediation within 60 days.

C7: If the OA Care Coordinator has not met required credentials or completed the required initial training, they are prohibited from performing Care Coordinator functions until completed. The OA Care Coordinator will gain the required credentials and/or complete the required training within 60 days.

C8: If the OA Care Coordinator credentials lapse or does not complete the required training they are prohibited from performing Care Coordinator functions until completed. The OA Care Coordinator will regain credentials and/or complete the required training 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	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.

There is a \$25,000 maximum per customer per 5 years period, for any combination of pest control, adaptive equipment, assistive technology, home modifications, Home Assessment by Occupational or Physical Therapist and vehicle modifications.

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.)*

All services provided in this waiver are delivered to individuals in their home settings which are presumed to be integrated. The same rules mentioned above as they relate to residential and non-residential settings are non-applicable and do not require any action by the State.

Any new service provider or setting must fully comport with the federal home and community-based (HCB) settings rule. The state will ensure that prior to approval of any provider for this service, it will evaluate the setting consistent with the manner specified in the Statewide Transition Plan for the HCB settings rule and that this service will be monitored for compliance with the rule at any amendment or renewal of this waiver.

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.)*

As part of the OA's continuous quality improvement efforts, the OA regularly reviews assessments, PCPs, mandated customer contacts, and nursing agency supervisory reports. They verify that the Care Coordinators discuss freedom of choice of providers, review progress towards goals, review medication changes, physical health, emotional health, social needs, educational and transition needs. This includes reviewing the PCP to assure that services are based on customer needs, strengths, and preferences and that the PCP includes individual goals and supports needed to meet desired outcomes.

Care coordinators are required to complete training that includes reviewing the PCP procedure, the care coordination toolbox with all related policies, examples, and resources, and completing a self-guided Motivational Interviewing learning module to support effective, family-centered planning.

Processes are in place to support customer engagement in meaningful, goal-driven activities while promoting autonomy, independence, and informed decision-making. This is accomplished through annual family surveys and the Family Advisory Council. Surveys include Likert-scale questions related to care coordination, along with open-ended questions on how the OA has been helpful and how services could be improved. The Family Advisory Council, comprising family members from across the state, meets regularly throughout the year to provide ongoing, direct feedback that informs service planning, quality improvement, and program development.

Oversight of the PCPs includes reviewing a statistically representative sample of waiver customer's PCPs and related assessments, back-up plans, and required contacts. Results are shared with the MA during quarterly quality improvement meetings. Additionally, the MA conducts validation reviews of the OA's quality assurance reviews by pulling a sample of records reviewed by the OA. The MA reviews to ensure comparable findings between MA and OA reviewers.

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:

Individual Service Plan

- a. Responsibility for Service Plan Development.** Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. 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:

Qualifications for OA Care Coordinators include one of the following:

Nurse Care Coordinator

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

Social Worker Care Coordinator

1) Master's degree in Social Work or Social Service Administration, and one of the following:

- Current State of IL Licensure as a Licensed Social Worker or Licensed Clinical Social Worker.

OR

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

2) Bachelors of Arts Degree or Science from an accredited college or university in social science, social work or in a related field, AND

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

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

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:

(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) Supports and information available to customer

OA Process:

The PCP begins with an assessment and re-assessment conducted by a Care Coordinator from the OA's regional office , and not linked to any provider of service. Effective March 2018, the OA became in full compliance with implementation of federal PCP requirements that encompasses a holistic approach. This included revision of the comprehensive assessment to encourage increased customer/authorized representative involvement in development of the PCP. Significant training was provided to Care Coordinators on the PCP process and all subsequent new Care Coordinator training has been updated to ensure the OA is in compliance.

Routine practice of the OA Care Coordinator includes asking the waiver customer the customer's family or legal representative, who they would like to attend their PCP development session.

The customer, the customer's family or legal representative, other individuals from the customer's support network as the customer, his or her family or guardian chooses, and the Care Coordinator work together to develop the Person Centered plan (PCP).

As the date and time is set for the PCP and discussion, the OA Care Coordinator is to make every accommodation possible to satisfy and include all persons identified by the customer and their family. It is expected that all conversations between the OA Care Coordinator 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 that the outcome of the process is a PCP that is holistic, owned, is agreed to by the customer and their family and is reflective of their needs, preferences, person-centered goals, safety, welfare, and health status.

The Care Coordinator provides information and support to enable the customer and his or her family or guardian to participate in and direct the planning process. The customer is informed of the types of services provided under the Waiver, as well as options of all willing and qualified providers. The Care Coordinator also shares helpful resources that are not covered through the waiver. The options discussed and the choices made are documented as part of the planning process.

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, and the customer's vision for his/her quality of life. The PCP begins with an initial comprehensive assessment of the customer's and family's strengths and needs. Through this initial assessment, the Care Coordinator builds a relationship with the customer and the family by gaining an understanding of their perspectives, gathering information, identifying their strengths and understanding the customer and family's needs and goals. The assessment gathers data in the following area: health, social/emotional, educational, financial, and transition. The assessment process is the discovery portion of the PCP that ultimately leads the customer and the family in the development and implementation of the PCP. Direct service providers do not play a direct role in the development of the PCP, nor do they attend any planning meetings, unless the customer or his or her legal representative requests their participation.

Care Coordinators are trained to discuss potential risks with the customer and work together to develop a PCP that will minimize or eliminate risk.

The PCP is in plain language and in a manner accessible to the customer. The written plan may be produced in other formats, such as pictures, DVD, etc., to accommodate specific needs of the customer; however, the PCP must exist in written format. The customer, his or her legal representative, if applicable, and the Care Coordinator all sign the PCP. Providers that participate in the development of the PCP must also sign the plan.

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 and other assessment forms utilized during the assessment/reassessment processes demonstrate that the waiver customer exercised choice in the decision-making process. 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.

The customer, his or her legal representative, if applicable, and direct service providers responsible for the PCP's implementation are given a written copy of the plan by the Care Coordinator when it is developed and whenever it is updated. The Customer and his or her legal guardian, if applicable, may also obtain a new copy of the PCP by requesting it of the Care Coordinator. The Care Coordinator attempts to contact customers/families, at least every 30 days. Although contacts are attempted every 30 days, a successful contact is required every 90 days. Attempts to contact and connect with the individual/family will begin by using the families preferred contact method. If contacts are unsuccessful, care coordinators are trained to attempt different methods of contact. Methods of contact include phone, videoconference, email, and US mail. Care coordinators will connect with other members of the individual's interdisciplinary care team to check accuracy of contact information or to relay that they are trying to reach an individual/family if they have been unsuccessful. During these contacts, progress towards goals is discussed and updates are made as needed. Annually the customer is informed about the process to request updates to the PCP and is informed of his/her right to request a revision to the PCP at any time.

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

This is to be given to all customers at the time of assessment and reassessment. As described in (a) above the OA Care Coordinator's practice requires that they routinely inquire and document the customer and family'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):

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

The Care Coordinator, the customer/family and entities chosen by the customer/family jointly develop the PCP. Minimally, the customer/family and the Care Coordinator participate in the process. The customer/family are informed that they may choose others to participate, including providers, family members, and friends. The PCP must be developed within 30 days after initial enrollment into the Home Care Program. It is then updated, at a minimum, annually or when there is a significant change in the customer's condition or supports.

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

The OA uses a comprehensive assessment with a holistic, strength-based approach. The assessment is the discovery portion of the PCP and focuses on the following areas: health, social/emotional, educational, financial, and transition. The assessment process ultimately leads the customer/family in the development and implementation of the PCP. The intention is to meet the customer/family where they are by building a relationship of trust and understanding in order to assist the customer and family in identifying and developing goals. Additionally, the comprehensive assessment prompts the Care Coordinator to ask questions that may identify health risks, such as substance abuse, sleeping disturbances, safety concerns, missed immunizations, etc. that could be addressed together with the family through education, referrals and information sharing. The assessment considers the customer's and family's background, and culture and specific preferences related to those areas.

The most important parts of the assessment process are getting to know the customer and their family, building a trusting relationship, and identifying possible goals with the customer and family. The assessment is a continual process throughout the course of care coordination. Care Coordinators use various assessment techniques, such as the use of Motivational Interviewing skills, trauma-informed practices, and other assessment approaches in order to engage the customer in the assessment process. The comprehensive assessment is a living document and an important part of the customer's record, and it is to be continuously updated with current information.

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

The OA provides information about waiver eligibility and waiver services during the initial enrollment process, and ongoing, during the frequent contact points with the customer. Contact points include: attempted focused assessments every 30 days (with a successful contact at least every 90 days), 6-month and annual face-to-face assessments. Attempts to contact and connect with the individual/family will begin by using the families preferred contact method. If contacts are unsuccessful, care coordinators are trained to attempt different methods of contact. Methods of contact include phone, videoconference, email, and US mail. Care coordinators will connect with other members of the individual's interdisciplinary care team to check accuracy of contact information or to relay that they are trying to reach an individual/family if they have been unsuccessful.

The OA care coordinator discusses available waiver services, non-waiver services, and other available resources with the family and customer during the comprehensive assessment and person-centered planning process.

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

The Care Coordinator conducts a comprehensive assessment and uses the information gathered to develop a PCP with goals that are important to and important for the customer. Many times, the Care Coordinator assists in identifying health-related goals. An example of a health-related goal is that the customer attends specialty physician visits. The Care Coordinator uses motivational interviewing techniques to assist customers with identifying their preferences and personal goals that are unique to them. The Care Coordinator also works with the customer and family to identify how assessed needs can be supported by waiver and non-waiver services. PCP development is guided by the customer and family and with the customer's preferences and goals in mind.

e) How the waiver and other services are coordinated;

The Care Coordinator identifies and assists the customer and their family in accessing waiver services and community resources to meet the customer and family's needs. Care coordinators assist with locating and scheduling of Medicaid

services such as: routine and specialty care visits, nursing services, home modifications, and vehicle modifications. Care Coordinators also assist customers and their families in utilizing public and private insurance and participates in Individual Education Plans (IEP) meetings, upon request. Lastly, the Care Coordinators make referrals to other community services such as food pantries, support groups, medical providers, and recreational opportunities that will support the needs of the customer and their family.

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

The assignment of responsibilities is included in the PCP development process initially and ongoing. The OA believes that collaboration is key for a successful PCP. Therefore, the OA has created a form for the customer/family and the Care Coordinator to sign that addresses the roles and responsibilities of each entity. This form is reviewed initially and at the time of each redetermination of eligibility. It includes expectations of the customer and family in meeting the customer's needs, including following through with health and medical care, working with service providers to facilitate in-home nursing care, and cooperating with program requirements such as routine contacts, assessments and PCP development and follow-up. The OA care coordinators monitor implementation of the PCP as part of the overall monitoring of health and welfare of the customer. If concerns are found, the OA has specific policies to address.

In addition to the oversight by the Care Coordinator, the approved nursing agencies are responsible to conduct nursing supervisor home visits every 60 days to monitor provision of nursing services. These reports are shared with the OA Care Coordinators who review to determine if additional supports are needed for the customer/family.

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

The OA Care Coordinators attempt to contact customers/families, at least every 30 days. Although contacts are attempted every 30 days, a successful contact is required every 90 days. Attempts to contact and connect with the individual/family will begin by using the families preferred contact method. If contacts are unsuccessful, care coordinators are trained to attempt different methods of contact. Methods of contact include phone, videoconference, email, and US mail. Care coordinators will connect with other members of the individual's interdisciplinary care team to check accuracy of contact information or to relay that they are trying to reach an individual/family if they have been unsuccessful. PCPs are updated at least annually and as indicated based on a change in customer status or support need. For example, families are informed to call the Care Coordinator if the customer becomes acutely ill and the physician has requested an increase in nursing services. If additional services are needed after a hospital discharge, the Care Coordinator works with the customer, family, nursing agency, the hospital and the MA to arrange the services. It is also common for a customer's medical status to improve, such as the case of decannulation of a customer with a tracheostomy. In these circumstances, the Care Coordinator works with the MA to review the need for continued services through the redetermination of eligibility.

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

Customers and anyone they wish to include have an active role in the development of the PCP. Illinois Administrative Rule 89 120.530 requires an opportunity be given to the customer/authorized representative to lead and direct the planning process, whenever possible, and to select other persons to participate in decision-making. This includes choosing services and service providers. The face-to-face comprehensive assessment is conducted in the customer's residence as this is most convenient for the customer and enables the Care Coordinator to see the customer function in their home environment.

(i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative.

After the Care Coordinator completes the comprehensive assessment, they discuss with the customer the array of services, regardless of funding sources which are available to them and for which they are eligible. Discussion also focuses on the customer's goals that may not be met by a waiver or other formal services. It is the Care Coordinator's responsibility to explain all service options to the customer, including, but not limited to waiver services. The customers are required to sign the PCP to ensure it adequately represents their goals and the PCP is designed as they want. Customers also sign a choice form verifying that service options were explained to them, and they had freedom

of choice in choosing their service and their service providers. The Care Coordinator provides a copy of the final person-centered plan and any subsequent revisions to the customer/authorized representative and any other person identified as being responsible for monitoring or implementing the plan, including relevant the providers. Additionally, the Care Coordinator conducts routine focused assessments and documents the periodic review of the PCP including information that is collected under the measures being used to evaluate the effectiveness of the services and supports based on the described needs and related conditions of the customer. Documentation is included in the OA Care Coordination system.

- 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.

Identification of risk is incorporated into the ongoing assessment process. The comprehensive assessment incorporates additional questions that identify areas associated with the Social Determinants of Health. The customer/family responses will prompt the Care Coordinator to ask additional questions, which will then allow the customer and the Care Coordinator to discuss further and determine the need for additional supports or resources. The comprehensive assessment also assists the Care Coordinator with asking questions that may identify certain health risks, such as substance abuse, sleeping disturbances, safety concerns, missed immunizations etc. that could be addressed with the family through education, referrals, and information sharing. The PCP development includes risk mitigation strategies to address assessed risks and may include more intense care coordination when indicated. This provides additional monitoring and support and evaluates the effectiveness of risk mitigation strategies. The customer and family are included in the discussion of risks and development of the plan.

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

Family caregivers are expected to meet the customer's needs to the fullest extent possible, including working with service providers. Nursing coverage may not always be at authorized levels. Families are counseled to be prepared for issues such as nurse illness, temporary staff shortage, or natural disaster. If a nursing shift is not covered the family must have a back-up plan with another trained caregiver. The trained caregiver is identified on the care plan developed by the nursing agency and the OAs electronic case management system. The back-up caregiver is fully trained in all tasks/skills. All back up plans are included in the Person-Centered Plan.

If a family indicates that they are having difficulty with staffing, several back-up arrangement options are discussed, such as using unpaid trained caregivers, training additional unpaid caregivers, changing the nursing agency, adding a second nursing agency, or recommending a short-term respite stay at an alternative care model facility until adequate coverage is secured. Plans for short term hospitalization may be a last resort if no other options are available.

The OA also employs a Staffing Support Specialist to work with the Care Coordinator, the OA administration and the MA administration collaborate to determine the barriers to nurse staffing and to develop individual and systematic strategies to improve staffing and avoid a failed home care plan. The Staffing Support Specialist becomes involved when all other strategies have failed.

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

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

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

As part of the focused assessment, Care Coordinators attempt to contact families at least every 30 days (with a successful contact every 90 days). Attempts to contact and connect with the individual/family will begin by using the families preferred contact method. If contacts are unsuccessful, care coordinators are trained to attempt different methods of contact. Methods of contact include phone, videoconference, email, and US mail. Care coordinators will connect with

other members of the individual's interdisciplinary care team to check accuracy of contact information or to relay that they are trying to reach an individual/family if they have been unsuccessful.

One of the things they ask about is staffing of nursing services. If the family indicates that services are not being fully covered, several options are discussed, such as training additional unpaid caregivers, changing the nursing agency, adding a second agency, or a short-term respite stay at an alternative care model facility until adequate coverage is secured. Sometimes it is necessary to have a care conference with the family and providers to resolve any ongoing issues that impact coverage. Plans for short term hospitalization may be a last resort if no other options are available. As part of this nurse staffing oversight process, the OA employs a Staffing Support Specialist to work with the Care Coordinator, the OA administration and the MA administration collaborate to determine the barriers to nurse staffing and to develop individual and systematic strategies to improve staffing and avoid a failed home care plan. The Staffing Support Specialist becomes involved when all other strategies have failed.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The primary services that waiver customers receive are in-home shift nursing and home medical equipment (HME) and supplies. For customers under the age of 21 these services are covered through EPSDT. For those customers over the age of 21, the services are covered through the waiver and State Plan. Nursing agencies provide both shift nursing and in-home respite to waiver customers. Care Coordinators assist customers with selecting their nursing agency and HME provider. Customers are informed that they may change service providers at any time. The OA provides a list of all approved providers that serve customers in the geographical area to customers and families upon entry into the program, upon request and as the need to change providers arises. The list is continually update.

The customer indicates choice was given by completing the Provider of Service Selection Form. The form is signed by the customer and the Care Coordinator. If the customer does not choose a provider on the approved provider list, the OA explains to them that the provider will not be reimbursed by the State for services. This is an option that is listed on the provider selection form.

The OA approved nursing agencies listed in Appendix C as Provider Types for waiver services, Respite, Nurse Training, Family Training, and In-home shift nursing for customers over age 21, are the same as those approved to provide in home shift nursing to eligible children through EPSDT. The nursing agency chosen by the customer is contacted to determine whether they are willing to provide the service and able to meet the needs of the customer.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The MA will conduct validation reviews of the OA's quality assurance reviews by pulling a sample of records reviewed by the OA. The MA will review in order to ensure comparable findings between MA and OA reviewers.

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:

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

Medicaid agency

Operating agency

Case manager

Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, 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.

(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);

The OA Care Coordinator is responsible for monitoring the implementation of the PCP and the customer's health and welfare. OA Care Coordinators carry an average caseload of 25 customers which allows them to have a thorough knowledge of their families and assist them in addressing their needs. Care Coordinators and customers develop the PCP together during the initial assessment and at each reassessment the PCP is reviewed and adjusted as needed. Waiver customers are provided with the opportunity to lead the PCP process. As required by 42 CFR 441.301(c)(3), the PCP must be reviewed, and revised upon reassessment of functional need, at least every 12 months, when there is a significant change in the participant's circumstances or needs, or at the request of the participant or family.

The PCP is developed as part of the comprehensive assessment which addresses all aspects of customer function and supports. After completing the comprehensive assessment and the PCP with the customer, the OA Care Coordinator identifies service needs, and supports and makes the appropriate referrals, as agreed upon by the customer and the OA Care Coordinator. Referrals are made for a variety of services including those outside the services offered in the waiver. OA Care Coordinators are trained to utilize local and regional funded services in addition to waiver services whenever appropriate.

(b) the monitoring and follow-up method(s) that are used;

The intensity of care coordination is customer centered and based on assessed risks and support needs discovered during the ongoing assessment process. The frequency of face-to-face visits and other types of contacts may be individualized based on the customer's preference and needs; however, at a minimum, contacts will be attempted every 30-days, with a successful contact every 90-days. Attempts to contact and connect with the individual/family will begin by using the families preferred contact method. If contacts are unsuccessful, care coordinators are trained to attempt different methods of contact. Methods of contact include phone, videoconference, email, and US mail. Care coordinators will connect with other members of the individual's interdisciplinary care team to check accuracy of contact information or to relay that they are trying to reach an individual/family if they have been unsuccessful. Families are informed to notify the Care Coordinator if needs change that may require a new assessment to determine if services or resources are needed or if the PCP needs to be modified.

If, during the regular family contacts, the family indicates that needs are not being addressed, several options are discussed, such as training additional unpaid caregivers; changing the nursing agency; adding another nursing agency, or is short-term out-of-home respite stay. Sometimes it is necessary to have a care conference with the customer, family and providers to resolve any ongoing issues that impact coverage.

Plans for short term hospitalization may be a last resort option if no other options are available.

(c) the frequency with which monitoring is performed.

The nursing agency also plays a role in monitoring the health and welfare of waiver customers. Nursing agency supervisors visit the customer's home every 60 days and send a summary report, including any changes or concerns, to the OA Care Coordinators for review and action, if appropriate. The supervisory visit includes a comprehensive physical assessment of the customer and also assesses other areas such as staffing needs, recent hospitalizations, changes in physical or emotional status of the customer, etc.

For difficult to staff cases, the OA Staffing Support Specialist will become involved when customers are at risk when authorized nursing hours are not fulfilled. The Staffing Support Specialist becomes involved after all routine methods to address staffing have been exhausted. The Staffing Support Specialist meets with the Care Coordinator, and administrative staff of the OA and MA to troubleshoot issues and find ways to successfully staff the case and assure the health and safety of the customer.

As part of the OA's continuous quality improvement efforts, the OA's Care Coordinator regional manager and/or the OA's Home Care Quality Improvement Unit regularly review assessments, PCPs, customer contacts, and nursing agency supervisory reports. They verify that the Care Coordinators discuss freedom of choice of providers, review progress towards goals, medication changes, physical health, emotional health, social, educational and transition needs.

The OA reviews a statistically representative sample of waiver customer's PCPs and related assessments, back-up plans, and required contacts. Results are shared with the MA during quarterly quality improvement meetings. The MA will conduct validation reviews of the OA's quality assurance reviews by pulling a sample of records reviewed by the OA. The MA will review in order to ensure comparable findings between MA and OA reviewers.

- 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 OA customers' Person Centered Plans (PCPs) that address all personal goals identified by the assessment. N: Number of OA customers' PCPs that address all personal goals identified by the assessment. D: Total number of OA 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: 	
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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:

D2: Number and percent of OA customers' Person Centered Plans (PCPs) that address all needs identified by the assessment. N: Number of OA customers' PCPs that address all needs identified by the assessment. D: Total number of OA customers' PCPs reviewed.

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

If 'Other' is selected, specify:

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

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

Performance Measure:

D3: Number and percent of OA customers' Person Centered Plans (PCPs) that address all health and safety risk factors identified by the assessment. N: Number of OA customers' PCPs that address all health and safety risk factors identified by the assessment. D: Total number of OA 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:	

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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:

- 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 OA customers' back-up plans that include a trained caregiver. N: Number of OA customers' back-up plans that include a trained caregiver. D: Total number of OA customers' back-up plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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

Performance Measure:

D5: Number and percent of OA customers who received face-to-face contact by their OA Care Coordinator every 6 months to monitor service provision or gaps in service delivery. N: Number of OA customers who received face-to-face contact by their OA Care Coordinator every 6 months to monitor service provision or gaps in service delivery. D: Total number of OA customers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA 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: 	

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:

D6: Number and percent of OA customers contacted by their OA Care Coordinator every 90-days in an effort to monitor service provision and address potential gaps in service delivery. N: Number of OA customers contacted by their OA Care Coordinator every 90-days in an effort to monitor service provision and address potential gaps in service delivery. D: Total number of OA customers.

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

If 'Other' is selected, specify:

OA Report

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

D7: Number and percent of OA waiver customers who have their Person Centered Plan (PCP) updated every 12 months. N: Number of OA waiver customers who have their PCP updated every 12 months. D: Total number of OA waiver customers reviewed.

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

PowerBI 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: 	

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:**D8: Number and percent of OA waiver customers that received updates to their**

Person Centered Plan (PCP) when there was a change in customer need. N: Number of OA waiver customers that received updates to their PCP when there was a change in customer need. D: Total number of OA waiver customers where a change in customer 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% 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:

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:

D9: Number and percent of OA waiver customers who received services in the type, scope, amount, duration, and frequency as specified in their Person Centered Plan (PCP). N: Number of OA waiver customers who received services in the type, scope, amount, duration, and frequency as specified in their PCP. D: Total number of OA waiver customers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA 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: 	

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

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

D10: # and % of OA waiver customers records that indicate choice was offered between waiver services and institutional care; and between/among services and providers. N: # of OA waiver customers records that indicate choice was offered between waiver services and institutional care; and between/among services and providers. D: Total number of OA waiver customers 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 <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:

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.

D1: If PCPs do not address required items, the OA/MA will require the PCPs be corrected and the OA will provide training of Care Coordinators. Remediation must be completed within 60 days.

D2: If PCPs do not address required items, the OA/MA will require the PCPs be corrected and OA will provide training of Care Coordinators. Remediation must be completed within 60 days.

D3: If PCPs do not address required items, the OA/MA will require the PCPs be corrected and OA will provide training of Care Coordinators. Remediation must be completed within 60 days.

D4: The OA will develop and implement a back up plan and revisions to customer PCP. Remediation must be completed within 30 days.

D5: OA will require customer be contacted and provide training the OA Care Coordinator. Remediation must be completed within 60 days.

D6: OA will require customer be contacted and provide training the Care Coordinator. Remediation must be completed within 60 days.

D7: OA will require completion of overdue PCPs and provide training the Care Coordinator. Remediation must be completed within 60 days.

D8: If plans do not address required items, the OA will require that the PCPs be corrected and provide training to the OA Care Coordinator. Remediation must be completed within 60 days.

D9: If a customer does not receive services as specified in the PCP, the OA will determine if a correction or adjustment of the PCP and services authorized is needed. If not, services will be implemented as authorized. The OA may also provide training to the OA Care Coordinator. If the issue appears to be fraudulent, it will be reported by the OA/MA. Remediation must be completed within 60 days.

D10: The OA will assure that choice was provided as shown by the correction of documentation to indicate customer choice. The OA may also provide training to Care Coordinators. Remediation must be completed within 60 days.

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.

The OA reviews and reports data on a quarterly basis. This performance data is then presented by OA Quality staff to the Regional Care Coordination Teams through a post-review discussion which focuses on strengths, root cause, patterns and trends, and compliance. At the time of the post review discussion all findings are shared and timelines for remediation are initiated. Systemic issues are discussed with input from regional teams on causes and resolutions.

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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Continuously and Ongoing
	Other Specify:

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

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

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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

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

Customers may initiate an appeal for:

- Refusal to accept a request for services;
- Finding of ineligibility;
- Failure to act on a request for services within the mandated time period;
- Denial of service; or
- Suspension, termination, or reduction of services.

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

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

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

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

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

The scheduling Medicaid Hearing Officer Supervisor creates a monthly report with the disposition of all cases to assure that hearings are being scheduled and moving through the process.

Decisions go through three levels of HFS review:

- 1) the Medicaid Hearing Officer drafts the case
- 2) the Medicaid Hearing Supervisor reviews 100% of the cases
- 3) the Medicaid Director makes the final decision on every case

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

- **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:

The OA operates the grievance and complaint system.

- **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 customer may file a grievance for any action or inaction taken by a DSCC staff member. Grievances may include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness, or failure to respect the customer's rights regardless of whether remedial action is requested. Grievance includes a customer's right to dispute an extension of time proposed by the OA. This includes a grievance related to the OA's performance of person-centered planning process, person-centered service plan, review of person-centered service plan, and when applicable, home and community-based settings, settings that are not home and community-based, home and community-based settings compliance and transition. It does not include dissatisfaction regarding reduced nursing staffing levels, or adverse benefit determinations, including but not limited to denied, reduced, or terminated services or supports; appeals processes exist for these purposes.

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

The OA will acknowledge each grievance received with a written letter of acknowledgement. The OA 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 OA 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 will get 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.

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

Customers are informed about their right to file a grievance and directions on the grievance process at enrollment, at each assessment and reassessment. Information about the grievance process can also be found on the website where grievances can be filed <https://dsccl.uic.edu/submit-a-grievance/>. Providers are provided with a standardized notice outlining the grievance process. This notice will be shared with providers as they are enrolled into the program. A grievance may be filed at any time, either orally or in writing, by the customer or their authorized representative. The OA can provide assistance to a customer in filing a grievance if requested. The OA provides support to families throughout the grievance process, which includes offering translation, telecommunications relay services (TRS), or additional supportive services as needed.

The OA's grievance process is documented in DSCC's Grievance Policy and Procedure. 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 filing a grievance or an authorized representative.
- The OA 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 or in writing.
- The OA 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 OA 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.

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).

An “Incident” is any occurrence or alleged occurrence that impacts or has the potential to impact the safety and well-being of a customer. This would include care provided by caregivers and professional entities. The OA separates incidents into two categories: critical and non-critical. A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or wellbeing of a customer. Non-critical are less severe in nature.

Types of critical incidents include incidents involving family members, other caregivers, or any professional individual or entity. Types of critical incidents include, but are not limited to, alleged abuse or neglect, exploitation, financial exploitation, death of a family member, harassment or bullying, medication or treatment errors, significant injuries, restraints or seclusions, and risk or threat of self-harm. Other examples of critical incidents include a caregiver suspected of being impaired by drugs or alcohol, sleeping while on duty, domestic crisis, or environmental concerns.

The nursing agencies and home medical equipment providers are to report all incidents of harm or potential harm to the OA Care Coordinator. The OA Care Coordinators report to the OA Quality Improvement Unit, who monitors that incidents are addressed and resolved.

When a Critical Incident is identified the Care Coordinator must:

1. Determine if an abuse/neglect Hotline call is required and follow through immediately. Suspected incidents of abuse, neglect, or exploitation must be reported to the appropriate State child welfare or adult protective services agency within 24 hours of learning about the situation.
2. Discuss the situation with an OA manager.
3. Enter an Incident Report in the OA electronic Care coordination system (ECCS) immediately, within 24 hours of learning about the situation.
4. Promptly notify the OA manger and OA Quality Improvement Unit that a report has been entered.

The following section describes State policies and laws regarding reporting for customers under age 18 years:

Any event that is alleged to result from physical or mental abuse, neglect or financial exploitation as described below is reported to the Illinois Department of Children and Family Services (DCFS), as the child welfare agency.

The Abused and Neglected Child Reporting Act - ANCRA (325 ILCS 5) sets forth the requirements for reporting and responding to situations of abuse and neglect against children under the age of 18. The types of critical incidents that must be reported include any specific incident of abuse or neglect or exploitation or a specific set of circumstances involving suspected abuse or neglect, where there is demonstrated harm to the child or a substantial risk of physical or sexual injury to the child. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child’s welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Reports made to DCFS for the children in the waiver may involve situations that would not normally be considered abuse or neglect. For example, failure to provide an environment that supports the technology or ensures access to emergency care can be life threatening because of the unique medical and technology needs of the children.

Although anyone may make a report, mandated reporters are professionals who may work with children in the course of their professional duties. There are seven groups of mandated reporters defined in the Abused and Neglected Child Reporting Act - ANCRA (325 ILCS 5/4). They include: medical personnel, school personnel, social service/mental health personnel (including staff of both the MA and the OA), law enforcement personnel, coroner/medical examiner personnel, child care personnel (including all staff at overnight, day care, pre-school or nursery school facilities, recreational program personnel, and foster parents), and members of the clergy.

Mandated reporters are required to report suspected child maltreatment immediately when they have reasonable cause to believe that a child known to them in their professional or official capacity may be an abused or neglected child. This is done by calling the DCFS 24-hour hotline (800-25-ABUSE). Reports must be confirmed in writing to the local investigation unit within 48 hours of the hotline call.

Customers ages 18 and over Adult Protective Services Act

The Adult Protective Services Act (320 ILCS 20/1 et seq.) authorized the Illinois Department on Aging to administer the Adult Protective Services (APS) Program to respond to reports of community-based abuse, neglect, self-neglect, or exploitation. The APS Program provides for intake, investigation, and follow-up of reported incidents. The APS Program is coordinated through 40 agencies located throughout the state and designated by the Area Agencies on Aging (AAA) and the IDoA. APS agencies conduct investigations and work with adults age 60 or older and adults age 18-59 with disabilities, in resolving the abuse, neglect, self-neglect, or financial exploitation. Persons can report suspected abuse, neglect self-neglect, or exploitation to the APS program by utilizing the APS Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week. They may also call the Senior Helpline at 1-800-252-8966 (voice) or 888-206-1327 (TTY).

Definitions of ANE

The APS program uses a set of definitions for critical incidents covering abuse, neglect, self-neglect or exploitation and other events that can place an individual at risk. These definitions can be found at 89 Ill. Adm. Code 270.210.

--Abuse means causing any physical, mental, or sexual injury to an eligible adult, including exploitation of such adult's financial resources {320 ILCS 20/2(a)}

--Neglect means another individual's failure to provide an eligible adult with or willful withholding from an eligible adult the necessities of life including, but not limited to food, clothing, shelter, or healthcare. This definition does not create any new affirmative duty to provide support to eligible adults. Nothing in the Act shall be construed to mean that an eligible adult is a victim of neglect because of healthcare services provided or not provided by licensed professionals {320 ILCS 20/2(g)}.

--Physical abuse means the causing of physical pain or injury to an eligible adult

--Sexual abuse means any sexual activity with an eligible adult who is unable to understand, unwilling to consent, threatened, or physically forced to engage in such sexual activity.

--Emotional abuse means verbal assaults, threats of maltreatment, harassment, or intimidation.

--Confinement means the failure by a caregiver to provide an eligible adult with the necessities of life including but not limited to food, clothing, shelter, or medical care because of failure to understand the eligible adults needs, lack of awareness of services to help meet needs, or lack of capacity to care for the eligible adult.

--Passive neglect means the caregiver's failure to provide an adult with life's necessities, including, but not limited to, food, clothing, shelter, or medical care.

--Willful deprivation means deliberate denial of an adult's medication, medical care, shelter, food, a therapeutic device, or other physical assistance and thereby exposing that person to the risk of physical, mental or emotional harm- does not include when the adult has expressed a desire to forego such medical care or treatment.

--Financial exploitation means the use of an eligible adult's resources by another to the disadvantage of that adult or the profit or advantage of a person other than that adult {320 ILCS 20/2(f-1)}.

More information and brochures regarding Elder Abuse Reporting may be found at:
<http://www.illinois.gov/aging/ProtectionAdvocacy/Pages/abuse.aspx>

Rules may be accessed through the IDoA's website at:
<http://www.illinois.gov/aging/AboutUs/Pages/rules-main.aspx>

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

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Customers and families are informed that the nurses and the OA staff are mandated reporters when they discuss the Roles and Responsibilities Form for the Home Care Program.

Families are also given a copy of the Guidelines for Parents with nurses in the home. This document contains information about abuse and neglect, explains that nurses are mandated reporters, and includes advice such as not to share money with the nurses and how to maintain boundaries with service providers.

The numbers to the Abuse and Neglect hotlines for DCFS and Adult Protective Services are listed on the Emergency Home Information list.

The OA provides the three documents initially and reviews the documents annually with the customers and families.

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

The OA receives reports of critical events or incidents and monitors them to resolution. The types of intervention or reporting are related to the nature of the event. OA Care Coordinators report to the OA Home Care Quality Improvement Unit when they are aware of reports made or they initiate a report to the Department of Children and Family Services (DCFS) or the Adult Protective Service (APS) hotline. The OA also reports incidents to the Illinois Department of Financial and Professional Regulations (IDFPR) when indicated. When the Home Care Quality Unit is notified of reports made to DCFS, APS or IDFPR for an investigation, the OA closely monitors the investigation. The results of the investigation are shared with the OA to confirm completion of the investigation.

The MA and OA do not play a direct role in the investigation of critical events that are reported through the State authorities that are responsible for conducting investigations. It is the OA's responsibility to report the incident and assure the health and safety of the waiver customer during the investigatory phase and after. If an incident is reported that does not rise to the level of the State investigatory authorities, the OA will work with the family or the provider to address and remediate the issue.

For each enrolled nursing agency and home medical equipment vendor, the OA enters into an agreement in addition to the MA's electronic enrollment system, known as IMPACT. This agreement clearly outlines abuse and neglect reporting requirements, incident reporting and other safeguards. If non-compliance of these additional standards are not met or other reports find a provider in non-compliance, new admissions will be held until compliance is met. If conditions found are a more immediate threat to a child or children, cases will be transferred to other providers.

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

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

1) Illinois Department of Children and Family Services (DCFS) for persons under age 18

Abuse/Neglect investigations are initiated without delay if immediate danger or harm is reported. Investigations are initiated within 24 hours after the report is taken if it relates to inadequate shelter or environmental neglect. DCFS has up to 60 days to complete an investigation and make the final determination. A 30-day extension can be granted for good cause.

Customers aged 17 and younger and their families, as appropriate, are notified within five calendar days of the completed investigation. The alleged perpetrator and customer's caretaker are notified in writing of the DCFS final finding within 10 days after final determination is entered into State Central Registry.

If a finding is indicated, the perpetrator's name is placed on the DCFS State Central Register for a minimum of 5 years, 20 years for serious physical injury and 50 years for sexual penetration or death. If the investigation is unfounded, the alleged perpetrator's name remains on the DCFS Register for a minimum of 30 days up to 3 years depending on the seriousness of the situation.

2) Adult Protective Services Act,

The State has passed legislation to consolidate to a single entity the reporting and investigation of abuse, neglect, financial exploitation (ANE), or self-neglect of eligible adults. The Illinois Department on Aging (DoA) will have the authority to receive reports and investigate ANE, expanding their current system. The Act will amend the Elder Abuse and Neglect Act and various Acts to change references to the short title - Adult Protective Services Act. The Act will repeal the Abuse of Adults with Disabilities Intervention Act, and hence, remove statutory authority from the DHS Office of Inspector General (OIG) to respond to allegations related to adults with disabilities, ages 18 through 59, who reside in domestic situations. The DoA will establish by rule mandatory standards for the investigations and mandatory procedures for linking eligible adults to appropriate services and supports.

Along with the above, the Act provides that the DoA:

- Establish a centralized Adult Protective Services Helpline for the purposes of reporting the ANE that is accessible 24 hours a day, 7 days a week and to post its telephone number online.

- Establish of a Statewide Fatality Review Team; and other matters. Effective July 1, 2013.

Certain activities are slated to be implemented upon the effective date of the Act, and others as is practical.

The DoA will use the same model for responding to allegations of abuse of adults with disabilities, ages 18-59, as it currently uses for adults age 60 and over. When a call is received alleging abuse, neglect or exploitation of an elderly person, intervention occurs within 24 hours, 72 hours or seven days, depending on the priority assigned to the nature of the allegation. Face-to-face visits are made within 24 hours of situations that are deemed life threatening or pose severe risks. The Elder Abuse Agencies will continue to work with older adults, age 60 and over, in resolving abusive situations. DoA is working with other State agencies to establish protocols for linkage to appropriate services and supports for persons ages 18 through 59.

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

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

The OA provides education for all new staff initially and ongoing as needed to make certain the waiver regulations, and the OA policies and procedures are followed. Nurses employed by approved nursing agencies providing services to customers in the MFTD waiver are required to sign the Illinois DCFS CANTS 22 form, Acknowledgment of Mandated Reporter Status, and complete the DCFS On-line Training for Mandated Reporters. By signing the OA requirements and standards, providers agree to comply with laws governing the reporting of abuse or neglect.

Annually the nursing agencies and home medical equipment providers review and sign the OA Requirements that include a statement "report all incidents of harm or potential harm to the OA Care Coordinator".

The critical event reports are entered into a database for additional analysis. Each incident is closely monitored and used in monitoring and identifying training and technical assistance needs.

OA staff responds to complaints, referrals or worrisome trends with more frequent reviews. For example, prior to sending the annual renewal packet, the OA reviews the database for patterns in the frequency of incident reports for the same nursing agency or HME provider. When a pattern is identified with a provider, the OA conducts an on-site review or contacts the agency administration.

Reports are generated by the OA on a quarterly basis or more often if necessary or requested by the MA. These reports are shared and reviewed with the MA at quarterly waiver quality meetings. High risk incidents including unusual deaths are shared with the MA and handled immediately.

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of restraints

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

--

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

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Restraints are only allowed when ordered by a physician for safety and positioning. Seclusion is not allowed. Restraints are not allowed for the purpose of punishment or convenience of the caregiver.

Allowable restraints are defined as any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the child to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the child's behavior or restrict the child's freedom of movement and is not a standard treatment or dosage for the child's condition. A restraint does not include orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or methods that involve physically holding the child to conduct routine physical exams or tests, or to protect the child from falling out of the bed, or to permit the child to participate in activities without the risk of harm.

Furthermore, restraints shall be used only for the safety and security of the child upon written order of the attending physician and with the formal consent of the child's representative. The physician's written authorization shall specify the precise time periods and conditions in which any restraints shall be employed. The reasons for ordering and using restraints shall be recorded in the child's person-centered plan of care. All staff who apply restraints are trained on the application prior to administering the restraint. Customers are monitored during the entire time the restraint is applied.

Restraints shall be used only for the safety and security of the customer upon written order of the attending physician and with the formal consent of the customer or customer's representative. The physician's written authorization shall specify the precise time periods and conditions in which any restraints shall be employed. The reasons for ordering and using restraints shall be recorded in the customer's plan of care. All staff who apply restraints are trained on the application prior to administering the restraint. A customer's physical, emotional, and psychological well-being is monitored during the entire time the restraint is applied. The customer is monitored to evaluate the immediate situation; reaction to the intervention; medical and behavioral condition; and the need to continue or discontinue the intervention.

Waiver services and supports are typically provided in the customer's home, but the waiver allows for services to be provided in community-based alternative health care settings as an adjunct to in-home care.

The waiver approves Children's Community-Based Health Care Centers (CCHCC) Model, licensed by the Illinois Department of Public Health (DPH) to provide nursing care and respite. DPH rule 77 Illinois Administrative Code (ILAC) 260 is the license authority.

The OA Care Coordinators are responsible for detecting the unauthorized use of restraints and assuring customer's health, safety, and welfare. The use of unauthorized use of restraints is monitored through bi-annual face-to-face visits and routine contacts with the customer and through reports by providers, family, or friends, as well as through the analysis of complaints or incidents.

77 Ill. Adm. Code 260.1900 m) and n), governing restraint use in the setting, under Child's Rights states:

m) Neither physical restraints nor confinements shall be employed for the purpose of punishment or for the convenience of any facility personnel or volunteer. Highchairs, playpens, cribs or youth beds are not restraints for children less than four years old.

Types of restraints permitted:

n) Restraints shall be used only for the safety and security of the customer upon written order of the attending physician and with the informed consent of the customer's representative. The physician's written authorization shall specify the precise time periods and conditions in which any restraints or confinements shall be employed. The reasons for ordering and using restraints shall be recorded in the customer's plan.

Alternatives to restraints: As stated above, only the restraints ordered by a physician for safety and positioning are utilized.

Due to the medical complexity of the MFTD population, most restraints are classified as a "clinical restraint". A "clinical restraint" refers to a physical or chemical restraint which is implemented based on a

medical reason, such as preventing a customer from engaging in a behavior which puts their medical safety at risk. In situations requiring “clinical restraint” a physician’s order is required. In the event that restraints are placed to ensure the immediate physical safety of the patient, the patient’s written Plan of Care is modified to include restraint protocol. Due to the associated safety risk and clinical nature of the need for such restraint, the implementation of alternative strategies pre-incident is not viable. MFTD waiver customers do not include customers who require institutionalization solely because of a severe mental or developmental impairment. Thus, In-Home support has a focus on the immediate medical aspect or medical needs of the customer.

Caregivers provide one-to-one direct support and services. Engagement should commonly consist of verbal prompting, physical cues, and redirection as part of their duties. Any level of engagement prescribed by a physician should be noted in the customer’s assessment of need. Interventions beyond these informal strategies (noted above) should be incorporated in the customer’s Plan of Care, Person-Centered Plan, and detailed in the Physician’s Order. The OA Requirements for Nursing Agencies Participating with the Illinois Department of Healthcare and Family Services Home Care Program agreement includes a policy on restraints and restrictive intervention.

The waiver approves Children's Community-Based Health Care Centers (CCHCC) Model, licensed by the Illinois Department of Public Health (DPH) to provide nursing care and respite. DPH rule 77 Illinois Administrative Code (ILAC) 260 is the license authority. The CCHCC maintains facility restraint compliance under this authority. Restraints shall be used only for the safety and security of the child upon written order of the attending physician and with the informed consent of the child's representative. The physician's written authorization shall specify the precise time periods and conditions in which any restraints shall be employed. The reasons for ordering and using restraints shall be recorded in the child's treatment plan. Staff shall be trained and be able to demonstrate, at least annually, competency in the application of restraints and in the monitoring, assessment, and provision of care for the client in restraints. The training shall include techniques to identify client behaviors and events that may trigger circumstances that require the use of restraints and the safe application and use of all types of restraints, including:

- 1) Training in how to recognize and respond to signs of physical and psychological distress; and
- 2) The clinical identification of specific behavioral or medical changes indicates that restraint is no longer necessary.

Restraints shall be used only for the safety and security of the customer upon written order of the attending physician and with the formal consent of the customer or customer’s representative. The physician’s written authorization shall specify the precise time periods and conditions in which any restraints shall be employed. The reasons for ordering and using restraints shall be recorded in the customer’s plan of care. All staff who apply restraints are trained on the application prior to administering the restraint. A customer’s physical, emotional, and psychological well-being is monitored during the entire time the restraint is applied. The customer is monitored to evaluate the immediate situation; reaction to the intervention; medical and behavioral condition; and the need to continue or discontinue the intervention.

The approved use of restraint is documented in the customer’s Plan of Care. State regulations require: 77 IAC 245.205 f)

1. The home nursing services team shall review the plan every 90 days, or more often should the patient's condition warrant.
2. An updated plan of treatment shall be given to the client's health care professional for review, for any necessary revisions, and for signature every 90 days, or more often as indicated.

The duties associated with In-Home Shift Nursing include keeping adequate records regarding health and reporting pertinent information. Each Home Nursing Agency is required to maintain clinical documentation. A record shall be maintained for each customer receiving in-home services. At a minimum, documentation is required by the home services worker of each of the services provided at each visit. Illinois Administrative Code 77 IAC 245 cites the documentation requirements of in-home services.

In the Requirements for Nursing Agencies Participating with the Illinois Department of Healthcare and Family Services Home Care Program agreement the nursing agencies are instructed to submit to the OA’s Care Coordinator written documentation of any incident that poses a threat to the child’s health or welfare,

including but not limited to injuries, medication errors, or use of restraints within 5 business days. Supervisory reports that include head-to-toe assessments from the nursing agency every 60 days.

Additional safeguards have been added to the annual provider agreement between the OA and the CCHCC. The OA requires that the CCHCC submit to the OA Care Coordinator written documentation and follow-up of any incident that poses a threat to the child's health or welfare, which includes the use of restraints. The incidents must be reported at the time of occurrence.

Training and Education: All staff must be trained on the type of restraint ordered by the physician. A customer specific checklist is used to orient staff on specific needs of the child including restraints, if applicable.

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

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

CONTINUED TO MAIN B OPTIONAL

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

Improper or inappropriate use of a restraint in the in-home setting is a reportable incident to the OA. Remediation or action taken is dependent on the circumstance.

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

The OA nursing agency provider requirements includes a policy on restraints and restrictive interventions. The OA reviews provider policies regarding restraints and restrictive interventions at least annually. If the restraints/restrictive interventions arise to the level of abuse or neglect, it must be reported to the appropriate State investigatory authority and the OA assures the health and safety of the waiver customer.

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

The Illinois Department of Public Health (DPH) conducts annual license and complaint investigation reviews of the CCHCCs. The protocol for annual license surveys includes a review of incidents and use of restraints during the previous year.

The OA shares immediate concerns with the MA at the time of the discovery. Summaries of monitoring reviews and findings are shared with the MA in a quarterly report. The quarterly reports are discussed at quarterly meetings.

The OA has several methods to detect potential incidents of unauthorized restraints:

- Nurse Supervisory visits are completed and include head-to-toe assessments from the nursing agency every 60 days.
- Reports of Critical Incidents from Care Coordination Team, Nursing Agency or Children's Community-Based Health Care Centers or family.
- Annual Nursing Agency and Children's Community-Based Health Care Center Quality reviews conducted by the OA.
- Care Coordination required face to face visits at least every 6 months.

In the Requirements for Nursing Agencies Participating with the Illinois Department of Healthcare and Family Services Home Care Program agreement the nursing agencies are instructed to submit to the OA's Care Coordinator written documentation of any incident that poses a threat to the child's health or welfare, including but not limited to injuries, medication errors, or use of restraints within 5 business days.

If during the annual nursing agency quality review or through other documentation, incidents including the inappropriate/ineffective use of restraints and seclusion are discovered, further review will be conducted, and remediation will occur.

The MFTD waiver request Care Coordination to complete a face-to-face visit with the customer, at least every 6 months. At this visit, the Care Coordination team should review and address any concerns noted during this time.

If a restraints/restrictive intervention arises to the level of abuse or neglect, it must be reported to the appropriate State investigatory authority and the OA assures the health and safety of the waiver customer. If substantiated, the OA will engage in remediation activities.

The OA uses care coordination software to collect the data. Then, a PowerBI report is reviewed to track incidents for trend analysis and to determine whether programmatic or other changes are needed to avoid

future occurrences.

Incident report data is collected and aggregated for further analysis of trends. The OA utilizes the trend data in order to assess staff and provider training needs in particular areas of risk involving participants and employees. This information will be reviewed with staff to gather information about challenges to timely reporting and to develop corrective actions plans. Home Care (MFTD Waiver) Incident Reports are reported to the MA quarterly.

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of restrictive interventions

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

Methods to detect unauthorized use of restrictive interventions:

The OA Care Coordinator is responsible for monitoring customer health and welfare through ongoing assessments and family contacts. The use of unauthorized restrictive interventions is monitored through bi-annual, face-to-face visits, and routine contact with the customer and through reports by providers, family, or friends, as well as through the analysis of complaints or incidents.

Nursing agency supervisors visit the customer's home every 60 days and send a summary report, including any changes or concerns, to the OA Care Coordinators for review. Unauthorized use of restrictive interventions that result in harm or potential mental or physical harm to the customer is a reportable incident to the OA. Remediation or action taken by the OA is dependent on the circumstance.

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of seclusion

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

The State does not permit seclusion.

Methods to detect seclusion:

The OA Care Coordinator is responsible for monitoring customer health and welfare through ongoing assessments and family contacts. The use of unauthorized seclusion is monitored through bi-annual, face-to-face visits, and routine contact with the customer and through reports by providers, family, or friends, as well as through the analysis of complaints or incidents. Nursing agency supervisors visit the customer's home every 60 days and send a summary report, including any changes or concerns, to the OA Care Coordinators for review. Use of seclusion is a reportable incident to the OA. Remediation or action taken by the OA is dependent on the circumstance and if determined to be necessary, a report will be filed with the Department of Children and Family Services, if it pertains to a customer under the age of 18 or to Adult Protective Services for customers over the age of 18 for an investigation of abuse.

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

In addition, the OA verifies annually that the nurses employed by the approved nursing agencies and CCHCCs have a current Illinois license. The OA conducts an onsite review at the approved nursing agencies and CCHCCs annually to verify compliance with the agreement and to review agency policy of use of restraint and seclusion.

Nursing agency onsite reviews also include family interviews of service satisfaction or care concerns.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

No. This Appendix is not applicable (do not complete the remaining items)

Yes. This Appendix applies (complete the remaining items)

- **Medication Management and Follow-Up**

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

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

DPH rule 77 Ill. Adm. Code 260 is the license authority. 77 Ill. Adm. Code 260.1620 Compliance with Licensed Prescriber's Orders, requires that:

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

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

2) Each single unit or unit dose package shall contain the proprietary and nonproprietary name of the drug and the strength of the dose. The name of the customer and the physician do not have to be on the label of the package, but they must be identified with the package in such a manner as to assure that the drug is administered to the correct resident.

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

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

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

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

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices

(e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The following medication errors must be reported to the OA: the 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.

All medication errors that result in medical intervention, hospitalization, or death must be reported to the Illinois Department of Public Health and the OA care coordinator.

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).

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

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

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

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

The Illinois Department of Public Health (DPH), as the licensing agency, is responsible for follow-up and oversight of medications error reporting in the Children's Community-Based Health Care Centers (CCHCC).

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

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

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

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

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

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

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

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

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

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

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

The OA verifies annually that the nurses employed by the CCHCC have a current Illinois license and conducts an onsite review at the CCHCC annually. The OA maintains a database of incidents to track trends and patterns.

The OA reviews the incident database prior to annual onsite review at the CCHCC. Also, incident and quality review results are included in the quarterly reports submitted to the MA.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

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 reviewed where the customer/guardian received info about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. N: Number of records reviewed where the customer/guardian received info about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. D: Total number 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 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:

G2 # and % of unexplained customer deaths and substantiated incidents of A/N/E reported to the OA that were reviewed/investigated within the required timeframes
N: # of unexplained customer deaths and substantiated incidents of A/N/E reported to the OA that were reviewed/investigated within the required timeframes
D: Total # of unexplained deaths and substantiated cases of A/N/E reported to the OA

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

If 'Other' is selected, specify:

OA 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: 	

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:

G3:# and % of customer deaths related to a substantiated case of abuse/neglect reported to the OA where appropriate actions were taken to address incident N:# of customer deaths related to a substantiated case of abuse/neglect reported to the OA where appropriate actions were taken to address incident D:Total # of customer deaths related to a substantiated case of abuse/neglect reported to the OA

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA 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: 	

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

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:

- 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. N: Number of critical incident trends where systemic intervention was implemented. D: Total number of critical incident trends.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA 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: 	

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:

- 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 substantiated incidents of restrictive intervention, including restraints, reported to the OA where appropriate actions were taken to address the incident N: # of substantiated incidents of restrictive intervention, including restraints, reported to the OA where appropriate actions were taken to address the incident. D: Total # of substantiated incidents of restrictive intervention

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA 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: 	

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:

G6: Number and percent of RNs, LPNs, and CNAs who received training on alternative practices to restrictive interventions, including restraints and seclusion. N: Number of RNs, LPNs, and CNAs who received training on alternative practices to restrictive interventions, including restraints and seclusion. D: Total number of RNs, LPNs, and CNAs.

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

If 'Other' is selected, specify:

OA Nursing Agency Review

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>
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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
	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:

- 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:

G8: Number and percent of survey respondents who report being treated well by nursing staff (RNs, LPNs, and CNAs). N: Number of survey respondents who report being treated well by nursing staff (RNs, LPNs, and CNAs). D: Total number of survey respondents reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA Survey

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

		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 <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:

G9: Number and percent of customers reporting that they visited a doctor or practitioner for an annual screening within the last 12 months. N: Number of customers reporting that they visited a doctor or practitioner for an annual screening within the last 12 months. D: Total number of customers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA 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: 	

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.

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

G2: The OA will follow up all outstanding Adult Protective Service (APS) referrals and substantiated incidents. Changes in customer's Person Centered Plan (PCP), corrective action plans or provider sanctions will be made when needed. Remediation must be completed within 30 days.

G3: The cause of death/circumstances would be reviewed by the OA 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 OA will review all outstanding critical incidents with the MA 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. Remediation must be completed within 30 days.

G5: The OA will follow up all outstanding APS and DCFS referrals of substantiated incidents incidents of confinement. Changes in customer's PCP, corrective action plans or provider sanctions will be made when needed. Remediation must be completed within 30 days.

G6: The OA will follow up to ensure that training on alternative practices to restrictive interventions, including restraints and seclusion, within 30 days.

G8: OA will follow up on survey result trends with Nursing Agencies to ensure customers are being treated well by support staff. Resolution or remediation will be based on the nature of the concern. Patterns of negative responses will be used to identify need for system improvement.

G9: The OA will ensure that customers receive annual preventive healthcare by confirming, during the Focus Assessment, whether the customer visited a doctor or practitioner for a screening in the last 12 months. If the customer has not received an annual screening, the OA will identify barriers and support the customer in scheduling an appointment. This may include assistance with locating a provider, coordinating transportation, or updating the PCP with relevant action steps. Remediation will occur during the customer's meeting with the OA Care Coordinator and must be documented in the electronic record 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 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 Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency (MA), and the University of Illinois-Chicago, Division of Specialized Care for Children, as the Operating Agency (OA), work in partnership to evaluate the waiver Quality Management System (QMS) and to analyze the information derived from discovery and remediation activities for each of the assurances.

Promoting a culture of quality within the OA is a top priority and highly valued. This quality culture includes an organization-wide philosophy of continuous quality improvement and utilizing evidence informed practices in its work and service delivery at all levels. The OA objectively, systematically, and continuously evaluates, monitors and improves the quality of internal processes, activities, programs and care coordination services provided to families and customers.

The OA supports quality initiatives, which include but are not limited to:

1. Annual strategic planning
2. A dedicated quality improvement department within the OA.
3. Establishment of an organization-wide ScoreCard.
4. Family/customer surveys sent at designated times to evaluate: care coordination, transition and education.
5. Regular record reviews to measure the compliance with program policies, procedures and quality of care coordination activities, including documentation.
6. A critical incident system that tracks incidents and includes trend analysis, leading to programmatic or other changes.
7. Regular training of staff on the quality improvement culture and techniques.

The OA has developed a Quality Improvement Culture to facilitate an environment in which quality activities and initiatives can be successfully achieved. The OA continually reviews and assesses quality improvement initiatives in order to continually learn and grow as an organization. This is accomplished by measuring progress towards established goals and obtaining feedback from internal and external stakeholders.

The OA is responsible for the majority of the data collection to address the Quality Management System discovery and remediation sections located in the Appendices. The State's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the assurances.

The sources of discovery evidence vary, but all are based on either a 100% or the representative sampling methodology as indicated for each performance measure. The OA conducts both onsite and/or remote reviews on a quarterly basis for OA Regional Offices, Nursing Agencies, and Children's Community-Based Health Care Centers. The OA conducts desk reviews annually for the Home Medical Equipment Providers. Data is collected throughout the year and individual problems are remediated as they are identified.

The MA will conduct validation reviews of the OA's quality assurance reviews by pulling a sample of records reviewed by the OA. The MA will review in order to ensure comparable findings between MA and OA reviewers.

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

Data is reported by individual performance measure. Individual performance measure reports include timeliness of remediation based on timelines identified in the waiver and includes progress on remediation.

The MA and OA identify trends based on scope, severity, changes and patterns of compliance. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement.

Suggestions for system changes are added to the OAs Waiver QMC System Improvement Log for tracking purposes. Decisions and timelines regarding system improvement are made based on consensus of priority and specific steps needed to accomplish change.

ii. System Improvement Activities

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

b. System Design Changes

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

Processes are outlined under each performance measure. The MA and OA work together to monitor and analyze performance measures on an ongoing basis. At least quarterly, key staff of the MA and the OA review progress, updates and evaluation of effectiveness. Effectiveness is measured by impact on performance based on ongoing data collection over time, feedback from customer/guardian interviews, record reviews, surveys from other agencies, and service provider reviews. Multiple years of data collection will allow the State to evaluate the effectiveness of system improvements over time.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Each year, one quarterly meeting is devoted to an overview of the previous year's activities and discussion of whether changes are needed to the overall Quality Improvement Strategy. At the meeting, the MA and OA discuss whether to make changes in existing performance measures, add measures or discontinue measures. The State continually strives to increase the compliance rate of each performance. This is done through continuous monitoring and remediation when needed.

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):

The OA has developed the following family surveys, which are currently being implemented. A Likert Scale is used to assess satisfaction. Surveys are sent for the following circumstances. The Family Surveys are sent by email daily and mail monthly, at the required timeframes below:

- Initial surveys are sent 60 days following enrollment with the program.
- Annual surveys are sent 1 year, 3 years, 5 years and then every 5 years following enrollment.
- Education surveys are sent when the customer turns the following ages: 3.5, 6, 8, 10 and 12.
- Transition surveys are sent when the customer turns the following ages: 14, 16, 18 and 20.
- Exit surveys are sent within 30 days of dis-enrolling with the program.

Additionally, each survey has two open ended questions that ask, 1. How has the OA been most helpful? and 2. What more can the OA do to help? Family survey data is utilized to consistently inform the OA about areas of strength and areas to continue to make improvements. The family survey reports are available to all managers, leaders and quality improvement staff. These reports can be reviewed with staff at any time to review the results, celebrate positive feedback and action plan when needed. Family survey data is reviewed during every Quarterly Quality Meeting. Additionally, Family Survey data is presented to the Family Advisory Council for their feedback and improvement ideas.

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.

Home nursing agencies are certified by the Illinois Department of Public Health (IDPH). The 210 ILCS 55/11 specifies the requirements of an annual attested financial statement. The following link provides details of this requirement: <https://ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1227&ChapterID=21>. No other providers of waiver services are required to secure an independent audit of their financial statements.

The Single Audit Act of 1984 (Act) and the Single Audit Act Amendments of 1996 applies to this Waiver. The 30 ILCS 5/3 specifies the jurisdiction of the Auditor General and section 3-2 identifies the mandatory post audits. In conjunction with the MA portion of the Statewide Single Audit, a sample of provider billings for Medicaid payments, that include billings for Medicaid payments for waiver services, are reviewed. The Illinois Office of the Auditor General is responsible for conducting the financial audit program.

Responsibility for Nursing Agency provider enrollment is a joint MA and OA responsibility. A preliminary screening by the OA verifies that the provider is licensed by the IDPH, in good-standing, has a minimal requirement of being in business for one year providing home-based services with adequate experience with specific technology and skilled care needs. The MA enrolls the provider in IMPACT.

Desk audits are conducted annually for nursing agencies. The OA uses a statistically valid sampling approach that uses a 95% confidence level and a +/-5% margin of error. An entrance and exit conference are conducted with the nursing agency provider, sharing findings during the exit conference. All findings must be corrected within 60 days. Remediation activities are tracked by the OA to ensure 100% remediation of findings. The OA verifies that the following requirements are met:

- All nurses selected in the sample, have documentation that they were reviewed against the Illinois Department of Children and Family Services (DCFS) Child Abuse and Neglect Tracking System (CANTS).
- All nurses selected in the sample, have documentation that they were reviewed against Illinois Department of Financial and Professional Regulation (IDFPR) to ensure the existence of no disqualifying circumstances.
- All nurses selected in the sample have documentation that they were reviewed against the Healthcare and Family Services Office of Inspector General (OIG) Provider Sanction List and the Department of Health and Human Services (HHS) Exclusion Database.
- All nurses selected for review meet the nursing agency training requirements, initially and ongoing.
- All Certified Nursing Assistants (CNAs) selected in the sample have a criminal background check completed and have no disqualifying convictions.

Additionally, the license and sanction status of 100% nurses caring for waiver customers are reviewed annually through IDFPR, OIG, and the HHS Exclusion list.

An onsite review is triggered if during the desk audit an issue of health, safety, or welfare of a customer is in question. For example, a pattern of deficiencies is noted, resulting from incomplete documentation of services, issues involving inadequate nursing care, lack of required documentation being maintained in the customer's home, issues with claiming, as well as any other item of situation that would rise to a level of heightened oversight. The OA would share the concern with the IDPH and accompany them on an onsite visit of the agency.

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.

Annually, the MA performs a desk audit 100% of claims for waiver services paid through MMIS and via the C-13 voucher process. Findings are shared via email with the OA. If a claim has been paid incorrectly, the federal claim is voided and resubmitted.

For waiver services paid through MMIS (respite, in-home shift nursing, and nurse training), the MA utilizes its Data Warehouse query capability to analyze 100% of paid waiver claims. The MA utilizes an exception report and review format as a component of the agency's financial accountability activity. The MA verifies the customer was eligible and enrolled in the waiver on date of service (DOS), the correct rate was paid for the service, all payments were made in accordance with the approved reimbursement methodology, and customer was not in an institutional setting on the DOS. The result of the review is presented to OA personnel via email with supporting claim detail. The OA advises the MA of corrective actions taken, including adjustments, for all service claims identified by the reviews that were not paid in accordance with defined parameters. In addition to the exception reviews of waiver claims, MA staff may conduct impromptu targeted onsite reviews of individual waiver services, utilization of waiver services by individual customers, and billing trends and patterns of

providers. If all findings are not remediated by the OA, the MA implements a corrective action plan to ensure 100% resolution of findings.

For waiver services paid via the C-13 voucher process (Home Accessibility Adaptations, Vehicle Modifications, Adaptive Equipment, Assistive Technology, Pest Control, Medical Operating Expense, Specialized Medical Equipment and Supplies, Family Training, and Placement Maintenance Counseling), the MA reviews 100% all C-13 vouchers, including those with high dollar amounts (>\$10,000).

The MA reviews the billing documentation as follows:

- 1) the customer was eligible and enrolled in the waiver on date of service (DOS)--unless the customer died before discharge or a significant change in condition occurred, and customer was unable to be discharged. In this case, the MA would file an administrative claim.
- 2) the invoice(s) supporting the service agrees to the C-13 that was paid,
- 3) The required bid is included for the following services: Home Accessibility Adaptations, Vehicle Modifications, Adaptive Equipment, Assistive Technology, Pest Control and Specialized Medical Equipment and Supplies
- 4) the OA has approved the service and the MA has approved the payment.

The result of the review of is presented to OA personnel via email with supporting detail. The OA advises the MA of corrective actions taken, including adjustments, for all service claims identified by the reviews that were not paid in accordance with defined parameters. The MA staff may conduct impromptu targeted onsite reviews of individual waiver services, utilization of waiver services by individual customers, and billing trends and patterns of providers. If all findings are not remediated by the OA, the MA implements a corrective action plan to ensure 100% resolution of findings.

To evaluate administrative claiming for Care Coordination activities, the OA conducts ongoing Random Moment Sampling (RMS) to document time and work activities of regional office care coordination staff. The time study data, combined with the administrative/operational costs, and are summarized in a Program Cost Study each fiscal quarter. The collection of the time and financial data allows the OA to document and allocate staff time and costs to the agency's programs and work activities. The RMS includes the identification and documentation of skilled nursing professional medical personnel in compliance with 42 CFR 432.50.

The Program Cost Study is compiled by MAXIMUS, Inc., a vendor contracted with the OA. The OA reconciles all costs incurred by the OA with the costs verified by the MAXIMUS report. This report is used to support the OA's administrative claims.

The OA submits a quarterly certification statement to the MA. This statement certifies the administrative claims, the cost of waiver services, and the Program Cost Study. This is reviewed by the MA for accuracy. The administrative claiming for case management expenses are claimed on the federal CMS 64. Once a year, a quarter of claims is chosen for a detailed review of the Program Cost Study by the MA. The OA submits expenditure reports to the MA for review. The administrative expenditure reports are reconciled to the Program Cost Study and costs are examined for applicability and allowability.

The State was approved for a Good Faith Effort exemption request for the implementation of an open/hybrid model Electronic Visit Verification (EVV) on November 21, 2019. On June 3, 2021, the MA posted a Request for Proposal (RFP) to secure the open/hybrid model Electronic Visit Verification (EVV). The winning bidder has been selected. The state anticipates the EVV system will be operational by the end of calendar year 2022. This system will be used for the personal care services (PCS) and Home Health Care Services (HHCS) as defined in the 21st Century Cures Act. PCS are defined as Activities of Daily Living (ADL), such as movement, bathing, dressing, toileting, transferring, and personal hygiene and Instrumental Activities of Daily Living (IADL), such as meal preparation, money management, shopping, and telephone use. PCS applicable to EVV are provided by Certified Nursing Assistants (CNAs) and CNAs through Respite services. HHCS are defined as personal care services or home health care services requiring an in-home visit by a provider that are provided under a state plan or 1915c waiver. HHCS applicable to EVV are provided by nurses through In-Home Shift Nursing. Customers have the choice to continue to use the current EVV system operated by the OA or change to the open/hybrid EVV model system that will be maintained by the MA. To ensure financial integrity and accountability, EVV will allow the state to monitor and reduce in unauthorized services, improve the quality of services to customers, and reduce fraud, waste and abuse.

(c) the agency (or agencies) responsible for conducting the financial audit program
The MA is responsible for or conducting the financial audit program.

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 and percent of payments that were paid for customers who were enrolled in the waiver on the date the service was delivered. N: Number of payments that were paid for customers who were enrolled in the waiver on the date the service was delivered. D: Total number of payments.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MA Data Warehouse

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

I2: Number and percent of payments made that were coded and paid only for services rendered as specified in the approved waiver. N: Number of payments made that were coded and paid only for services rendered as specified in the approved waiver. D: Total number of payments reviewed.

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

If 'Other' is selected, specify:

Paid Claims

Responsible 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

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:

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. N: Number of rates that are consistent with the approved rate methodology throughout the five-year waiver cycle. D: Total number of rates.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MA Data Warehouse

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

		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:

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

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

For the waiver claims review, the Medicaid Agency (HFS) staff utilize the HFS Electronic Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The MA staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, the MA conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted.

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 MA will require the OA to void the federal claim for services provided prior to the customer's waiver enrollment. Remediation must be completed within 30 days. The MA will adjust the federal claim for services provided by the OA prior to the customer's waiver enrollment. Remediation must be completed within 30 days.

I2: The OA will determine whether the service was coded and paid correctly and authorized in the PCP. If missing from the PCP, the OA is notified and the PCP will be revised to include the service. If coded and/or paid incorrectly, the OA is notified and the federal claim is voided and resubmitted. Remediation must be completed within 30 days.

I3: The MA will require the OA correct the incorrect 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
	Continuously and Ongoing
	Other Specify: Semi-Annually

c. Timelines

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

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing

identified strategies, and the parties responsible for its operation.

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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 renewal of this waiver is detailed in Main Section 6-I.

Rate determination methods for each waiver service is outlined below. Families receive a copy of the HFS 2352 which details the approved services and rates of payment.

Rates for waiver services are reviewed minimally every 5 years to ensure rates are adequate to maintain an ample provider base, quality of service, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. Rates for waiver services do not vary based upon geography or by provider, do not include room and board, and do not include transportation.

In-home Shift Nursing:

In-home shift nursing for customers over age 21 is a waiver service. The rates for in-home shift nursing are aligned with nursing rates in the State Plan. In-home shift nursing for customers under age 21 is covered under the State Plan. The rates were last reviewed and increased in 2024.

In-home Shift Nursing rates:

RN: \$45.00

LPN: \$37.50

Amendment IL.0278.R06.01 effective 01/01/2024 increased the In-Home Shift Nursing rates in response to legislation passed by the Illinois General Assembly Medicaid Omnibus bill, SB1298. The new rates were:

RN: \$54.00

LPN: \$45.00

Amendment IL.0278.R06.02 effective 01/01/2025, will increase the In-Home Shift Nursing rates in response to Public Act 103-0593. The new rates are:

RN: \$57.78

LPN: \$48.15

Certified Nursing Assistant (CNA):

CNA rates are based on the State Plan rate for Home Health Aide. CNA rates are not geographically based. Room and board and transportation are not included in the rate. The CNA rate was last reviewed and updated in 2024.

Reimbursement rates are posted on the MA website at

<https://hfs.illinois.gov/medicalproviders/medicaidreimbursement/hhfeeschedule.html>.

CNA: \$25.00

Amendment IL.0278.R06.01 effective 01/01/2024 increased the CNA rate in response to legislation passed by the Illinois General Assembly Medicaid Omnibus bill, SB1298. The new rate was:

CNA: \$30.00

Amendment IL.0278.R06.02 effective 01/01/2025, will increase the CNA rate in response to Public Act 103-0593. The new rate is:

CNA: \$32.10

Respite (in-home):

The MA establishes the rates for in-home respite based on the nursing and CNA rates in the State Plan, as detailed above. The rates were last reviewed and increased in 2024.

Respite (in-home) rates:

RN: \$45.00

LPN: \$37.50

CNA: \$25.00

Amendment IL.0278.R06.01 effective 01/01/2024 increased the Respite (in-home) rates in response to legislation passed by the Illinois General Assembly Medicaid Omnibus bill, SB1298. The new rates were:

RN: \$54.00

LPN: \$45.00

CNA: \$30.00

Amendment IL.0278.R06.02 effective 01/01/2025, will increase the Respite (in-home) rates in response Public Act 103-0593. The new rates are:

RN: \$57.78

LPN: \$48.15

CNA: \$32.10

Respite (out-of-home):

The MA establishes rates for center-based, out-of-home respite services. The rate has historically been paid as an hourly rate based on averaging utilization of licensed and non-licensed nursing rates that are established through the State Plan for in-home shift nursing. In this renewal, the rate is being aligned with the RN in-home shift nursing rate as outlined above.

Respite (out-of-home) rate: \$45.00

Amendment IL.0278.R06.01 increased the Respite (out of home) rates effective 1/1/2024 to:

Respite (out of home) rate: \$54.00

Amendment IL.0278.R06.02 effective 1/1/2025, will increase the Respite (out of home) rates to:

Respite (out of home) rate: \$57.78

Nurse Training:

The nurse training rate is based on the hourly rate for RN and LPN in-home shift nursing as detailed above. This service is prior approved by the MA.

Nurse Training rates:

RN: \$45.00

LPN: \$37.50

Amendment IL.0278.R06.01 increased the Nurse Training rates effective 1/1/2024 to:

RN: \$54.00

LPN: \$45.00

Amendment IL.0278.R06.02 effective 1/1/2025, will increase the Nurse Training rates in response to Public Act 103-0593. The new rates are:

RN: \$57.78

LPN: \$48.15

Family Training:

Family training rates are established by the MA through the State Plan and require prior approval by the MA. Family training may be provided by a nurse or by a community-based entity. The family training rates are based on the hourly RN and LPN in-home shift nursing rates as described above. Family training may also include other types of training, such as CPR. If other types of training are provided the rates may vary. All family training must be included in the customer's Person Centered Plan. The MA pays the public rate for the service.

Family Training rates:

RN: \$45.00

LPN: \$37.50

Amendment IL.0278.R06.02 effective 1/1/2025, will increase the Family Training rates in response to Public Act 103-0593. The new rate is \$53.50 per hour.

The rates for in-home shift nursing, in-home respite, out-of-home respite, nurse training, and family training rates are based on the rates in the State Plan and are available to the public at the following link:

<https://hfs.illinois.gov/medicalproviders/medicaidreimbursement/hhfeeschedule.html>

Reimbursement is codified in the MA's administrative rules at 89 Ill. Adm. Code 140.474(c).

Amendment IL.0278.R06.02 effective 01/01/2025, breaks out services formerly grouped under the Environmental Accessibility Adaptations service umbrella into separate services. The new separate services include Pest Control, Home Accessibility Modification, and Vehicle Modification. This amendment also adds Adaptive Equipment and Assistive Technology as new waiver services.

Home Accessibility Modifications, Vehicle Modifications, Adaptive Equipment, Assistive Technology, Pest Control, Home Assessment by Occupational or Physical Therapist (OT/PT assessment added in Amendment IL.0278.R06.03 effective 07/01/2026) and Specialized Medical Equipment and Supplies are paid at the vendor's charges. The rate is based on the usual and customary charges for these services. These services require prior approved by the OA to determine medical necessity prior to the item being supplied, with the exception of pest control which is a post-approval. The MA has established a cap of \$25,000 over a five-year period for a combination of these services.

Placement Maintenance Counseling Services:

MA establishes the rate for placement maintenance counseling. It is based on the rate for Illinois Department of Human Services rates for counseling services. The service requires prior approved by the OA. The Placement Maintenance Counseling rate was last reviewed and increased 2022.

Placement Maintenance Counseling rate: \$86.28

Amendment IL.0278.R06.03 effective 07/01/2026, or upon CMS approval

Assessment by an Occupational or Physical Therapist:

Rate is \$111 per visit (up to 2 hours). The rate is the same as the State Plan rate for a similar service. This service is included in the \$25,000 cap over a five-year period.

State Plan services are reviewed minimally every five years to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. Therapy rates are not geographically based and do not include room and board. The State reviewed the rates for agency-based providers in calendar year 2023 and no increase was implemented. Current rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. In the future, these rates will be reviewed minimally every five years.

These rates are based upon the Home Health Fee Schedule:

<https://hfs.illinois.gov/medicalproviders/medicaidreimbursement/hhfeeschedule.html>

- 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:

In Home Shift Nursing:

In Home Shift Nursing is billed and paid through the OA, using an HFS appropriation. The interagency agreement between the OA and MA specifically identifies the program and fiscal responsibilities of both agencies in their efforts to administer the waiver program. As part of the agreement, the OA is assigned the responsibility to maintain a provider data base of IMPACT-enrolled nursing and respite providers and to receive and adjudicate claims for these services as they relate to an eligible customer and their home care plan of care.

The OA claims processors review the claims received from approved providers and reconcile the services charged with the customer's approved plan of care. Once the charges are approved for payment, a voucher file is created for payment by the State. The OA then creates an electronic payment file to send to the State Comptroller. The nursing agencies are paid on an expedited schedule from an HFS' State appropriation. The OA sends a separate electronic claims file to HFS to record each claim transaction into HFS' Medicaid Management Information System (MMIS). The OA and HFS fiscal staff complete a claims and appropriation reconciliation on a quarterly basis to assure the payments made to the nursing providers agree to the payments posted into the HFS claims system. The provider voluntarily completes a provider agreement that reassigns payment from HFS to the OA.

Respite (in-home):

In-home respite is billed and paid through the OA, using an HFS appropriation. The interagency agreement between the OA and MA specifically identifies the program and fiscal responsibilities of both agencies in their efforts to administer the waiver program. As part of the agreement, the OA is assigned the responsibility to maintain a provider data base of IMPACT-enrolled nursing and respite providers and to receive and adjudicate claims for these services as they relate to an eligible customer and their home plan of care.

The OA claims processors review the claims received from approved providers and reconcile the services charged with the customer's plan of care. Once the charges are approved for payment, a voucher file is created for payment by the State. The OA then creates an electronic payment file to send to the State Comptroller. The nursing agencies are paid on an expedited schedule from an HFS' State appropriation. The OA sends a separate electronic claims file to HFS to record each claim transaction into HFS' MMIS. The OA and HFS fiscal staff complete a claims and appropriation reconciliation on a regular basis to assure the payments made to the nursing providers agree to the payments posted into the HFS claims system. The provider voluntarily completes a provider agreement that reassigns payment from HFS to the OA.

Respite (out-of-home):

Respite care provided by a facility established as a Children's Community-Based Health Care Center pursuant to the Alternative Health Care Delivery Act [210ILCS 3/35], is billed directly to the OA. The flow of billings is described above. The only difference is that payments are made to the Children's Community-Based Health Care Center.

Nurse Training: The OA care coordinators submit requests for nurse training to the MA for prior approval. Once approved, the OA creates an electronic payment file to send to the State Comptroller for payment using the MA appropriation. After payment is made, an electronic file is submitted to the MA's MMIS for processing federal match.

Family Training:

The OA care coordinators submit requests for family training to the OA for prior approval. These services are billed directly to the MA and paid through a manual (C-13) voucher process.

Home Accessibility Adaptations, Vehicle Modifications, Assistive Technology, Adaptive Equipment, Specialized Medical Equipment and Supplies: The OA Care Coordinators obtain the required bid from potential vendor and submits the bid along with supporting documentation to the OA's prior approval unit for final determination prior to the service being rendered. If approved, the OA prior approval unit sends written notification to the OA Care Coordinator that the work or service has been authorized. The OA Care Coordinator contacts the family and/or vendor. The claim is received by the OA Care Coordinator who verifies completion of the work or provision of service. If approved, the voucher is forwarded to the MA for payment using a manual (C-13) voucher process.

Pest Control: This is a post-approval due to the emergent need to rid vermin for medically fragile, technology dependent customers. The OA Care Coordinators will require documentation of the assessment of need for services and detailed

billing of actions taken to rid pests. The OA Care Coordinator will require the family to confirm that services were delivered. Upon approval, the voucher will be forwarded to the MA for payment using a manual (C-13) voucher process.

Placement Maintenance Counseling:

The OA Care Coordinators submit requests for payment of maintenance counseling to the MA for payment. These services are then sent to the MA and paid through a manual (C-13) voucher process.

If a provider chooses not to assign payment to the OA, this will be entered in the MA's IMPACT enrollment system and be paid directly by the MA.

(CONTINUED IN MAIN B OPTIONAL)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Both the OA and MA validate provider billings. Below is a description of the billing validation process for each service. Respite (in-home and out-of-home), in-home shift nursing, and nurse training:

After the OA approves the services and charges for payment, a voucher file is created and the providers are paid. The OA claims processing unit verifies the hours of nursing and respite that are approved when processing the claims.

The OA then sends a separate electronic claims file to the MA to record each claim transaction into the Medicaid Management Information System (MMIS). The MMIS applies processing edits to verify Medicaid eligibility for the customer, reject duplicate claims, adjust claims with third party liability etc. Any rejections are sent back to the OA via a remittance advice for review and reconciliation. Post-payment reviews of provider records are performed by the OA and post-payment audits performed by MA. The OA and HFS fiscal staff complete a claims and appropriation reconciliation on a quarterly basis to assure the payments made to the nursing providers agree to the payments posted into the HFS claims system.

To verify that services were rendered, the OA claims unit has a prior approval in place and they receive an accurate bill, they process the payment. The MA then conducts a review based on a statistically valid sample to assure that the services billed were rendered.

Services paid outside of the MMIS by the MA via C-13 Process through the MA Systems, Applications, and Products:

All other services are paid by the MA through the SAP which stands for “Systems, Application, and Products”. Customer and provider eligibility for the date of service are checked each time a payment for a waiver service is processed. A printout of the eligibility screen is included as part of the backup documentation for each payment voucher. As part of case management responsibilities, the OA Care Coordinators verify that the service is included in the approved service plan. The Care Coordinator regularly contacts family and discusses services provided since the last contact. This would include discussion that Environmental Accessibility Adaptations, family training and placement maintenance counseling was conducted.

Verification of home modifications and special equipment may also be performed by the OA through home visits. Home visits are made as often as needed and may be done for this purpose. Phone contact with the parent may verify the work was done. Nursing agencies also indicate changes to the home environment in the 60 day supervisory summary report.

When a provider has been overpaid, the OA claims unit will process an adjustment that will recoup the funds on the next payment of service for that customer. If the provider is no longer serving that customer, then a refund check is requested. Once the check is received, it is forwarded to HFS for processing. The OA adjusts the claim to reflect the credit on the original payment. Both of these processes result in a modified claim record being sent in the MA’s encounter data file. This is so that the MA’s records are corrected to reflect the credit adjustment. The MA then credits the FFP.

- 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:

(a) The waiver services that are not paid through an approved MMIS;

The following waiver services are paid through the SAP through a manual C-13 process: Home Accessibility Adaptations, Vehicle Modifications, Assistive Technology, Adaptive Equipment, Specialized Medical Equipment and Supplies, Pest Control and Medical Operating Expenses.

(b) The process for making such payments and the entity that processes payments;

The OA prior approval unit reviews all services for medical necessity and informs the OA Care Coordinator. The Care Coordinator verifies the provision of services and then submits the bill to the MA for processing. These services are paid on a C-13 Payment Voucher through SAP. The C-13 vouchers are prepared by the MA.

(c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS;

As stated previously, the OA pays nursing agencies and the Children's Community-Based Health Care Center directly for nursing services; and pays nursing agencies for nurse training.

The OA pays the bills directly, using an MA appropriation. The OA maintains a provider database of the IMPACT-enrolled approved nursing, respite and nurse training providers. The OA's claims processors review the bills received from approved providers and reconcile the services charged with the customer's approved treatment plan. Once the charges are approved for payment, a voucher file is created for payment by the State. The OA creates an electronic payment file to send to the State Comptroller. The nursing agencies and Community-Based Children's Health Care Center are paid on an expedited schedule from an MA State appropriation. The OA sends a separate electronic claims file to the MA to record each claim transaction into the Medicaid Management Information System. The OA and MA fiscal staff complete a claims and appropriation reconciliation on a regular basis to assure the payments made to the providers agree with the payments posted into the MA's claims system. The provider voluntarily completes a provider agreement that reassigns payment from the MA to the OA. The draw of federal funds is on the CMS-64, and is based on approved HCPC codes, eligible providers, and medical eligibility of the customer for the date of service. If a provider chooses not to assign payment to the OA, this will be entered in the MA's IMPACT enrollment system and be paid directly by the MA.

(d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64;

The draw of federal funds and claiming of these waiver services on the CMS-64 is based on the following "WBS" Elements:

478/542/M15D/0EM-0EM-9 – Equipment/Supplies/Electrical Modifications/Van Lifts/Bathroom Mods, Vehicle Modifications, Home Accessibility Modifications, Assistive Technology, Adaptive Equipment, etc.

478/542/M15D/0EM-0ES-9 – Pest Control

478/542/M15D/0EM-0CS-9 – Counseling Services

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The OA serves as a limited fiscal agent for paying respite and nurse training claims. Functions are described in above sections: a) Flow of Billings and d) Billing Validation Process.

All nursing agencies are given the opportunity to bill the MA directly or sign an alternative provider agreement (HFS 1413A) that allows them to voluntarily choose billing through the OA.

MA oversight follows:

Once a year a quarter is chosen for a detailed review of the Program Cost Study. The OA submits expenditure reports to the MA for review. These expenditure reports are reconciled to the Program Cost Study and costs are examined to ensure they are applicable and allowable.

During the waiver renewal period, the MA monitors the financial aspects of the waiver from a global perspective. The MA uses its medical Electronic data warehouse query capability to determine if customers are in a nursing facility and also receiving waiver services or determine if waiver services are being claimed after the death of a customer.

Since most of the waiver services are paid via C-13, a sample of C-13s is selected each year for review. The applicable documentation supporting the C-13s is reviewed to ensure that the services meet all waiver criteria.

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

To the OA for respite and nurse training services.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

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:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	13831.14	166588.83	180419.97	250242.93	54230.13	304473.06	124053.09
2	14194.69	170237.95	184432.64	256243.99	56485.85	312729.84	128297.20
3	19138.48	173420.13	192558.61	261576.45	58651.20	320227.65	127669.04
4	20978.64	176655.15	197633.79	267022.50	60898.04	327920.54	130286.75
5	23744.65	179943.82	203688.47	272584.78	63229.41	335814.19	132125.72

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:	Level of Care:
		Hospital	Nursing Facility
Year 1	1588	905	683
Year 2	1696	967	729

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:	Level of Care:
		Hospital	Nursing Facility
Year 3	1804	1028	776
Year 4	1912	1090	822
Year 5	2020	1151	869

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 is equal to the projected total number of days customers will be enrolled in the waiver divided by the unduplicated customer count. The ALOS has been projected based on March 2022 enrollment in MMIS and in the waiver and assumptions of 21 new, i.e., phase-in, enrollees per month and 12 departing, i.e., phase-out, enrollees per month throughout the five-year waiver period. The enrollee phase-in and phase-out assumptions were based on historical changes in waiver enrollment in MMIS from January 2017 through March 2020, prior to the COVID-19 public health emergency, and to ensure appropriate slots are held for new entrants.

The phase-in and phase-out projections are detailed in Attachment #1 of Appendix B-3-d.

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, the previously submitted CMS 372 reports were found to be overstated. Instead of relying on the submitted 372 reports, estimates were developed using claims and enrollment data in the State's MMIS system from September 2017 through March 2022 and claims paid through C-13 invoices. Users, units, and paid amounts were summarized by waiver service separately for each waiver year between September 2017 and August 2021. These summaries are similar to 372 reports, except all runout is through March 2022 rather than six or eighteen months.

Factor D estimates for each waiver year are the sum of expenditures for each waiver service divided by the number of unduplicated waiver customers 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 for each waiver service: Unduplicated users for each waiver service were estimated by multiplying the percent of total unduplicated customers receiving each waiver service by the total unduplicated customer count for each waiver year. The percent of total unduplicated customers receiving each waiver service were based upon historical experience between September 2019 and August 2020 (WY3), except that historical experience from September 2017 through August 2018 (WY1) was used for Environmental Accessibility Adaptations due to incomplete C-13 invoices for these services in other waiver years. For services with no historical experience (Specialized Medical Equipment and Supplies, Family Training, and Placement Maintenance and Counseling Services), assumptions were provided by the OA as these services are expected to be promoted in the new waiver period. The average number of users for these services were assumed to have five users per waiver year. This is intended as a placeholder to keep the line of service open for potential future utilization. The OA plans to work with care coordinators to increase the knowledge of availability of these services.

-Average units per user: The average units per user for each waiver service was based upon historical experience in WY3 in MMIS, except that historical experience from C-13 invoices from WY1 was used for Environmental Accessibility Adaptations (due to incomplete C-13 invoices for these service in other waiver years) and historical experience from September 2020 through August 2021 (WY4) in MMIS was used for In Home Shift Nursing. In Home Shift Nursing utilization in WY4 was consistent with WY1 and WY2. For other services with no historical experience, average units per user were assumed to be consistent with the most recent waiver amendment (IL.0278.R05.06). For Specialized Medical Equipment and Environmental Accessibility Adaptations, the average units per user do not vary in the new waiver years because they typically do not recur on a regular basis. For all other waiver services, the average units per user in the historical experience were normalized for the change in ALOS between the historical experience and the new waiver years.

-Average cost per unit: The average cost per unit was based on current fee schedules for Respite, CNA, Family Training, In Home Shift Nursing, Nurse Training, and Placement Maintenance Counseling services. There are no known fee schedule changes for these services during the new waiver period. For Specialized Medical Equipment and Supplies, average cost per unit was assumed to be consistent with the most recent waiver amendment (IL.0278.R05.06); a 2.5% annual unit cost trend was applied due to anticipated inflation. For Environmental Accessibility Adaptations, the average cost per unit was based upon historical experience (C-13 invoices) in WY3 and a 2.5% annual unit cost trend due to anticipated inflation.

Amendment IL.0278.R06.01 effective 1/1/2024:

The rate increase for In-Home Shift Nursing, Respite (in-home), and CNA is effective 1/1/2024 and is in response to legislation passed by the Illinois General Assembly in the Medicaid Omnibus bill, SB1298. Nurse training hours are being increased from 4-hour maximum to a 32-hour maximum. This is necessary due to the medical complexity and technology needs of this population. Four hours of individualized training is typically not sufficient to fully train a nurse on a medically complex person. In order to properly address the medical and technology needs of this population, the nursing agencies have been training beyond the 4-hour maximum without reimbursement for the additional hours. With this increase in hours, the State will be able to reimburse the nursing agencies for this much needed training.

--RN will increase from \$45 per hour to \$54 per hour. This will include shift nursing, respite nursing, and nurse training services.

--LPN will increase from \$37.50 per hour to \$45 per hour. This will include shift nursing, respite nursing, and nurse training services.

--CNA will increase from \$25 per hour to \$30 per hour. This will include CNA shift services and CNA respite services.

--Facility based respite will also increase from \$45 per hour to \$54 per hour.

Amendment IL.0278.R06.02 effective 01/01/2025, or upon CMS approval, in response to Public Act 103-0593 will increase rates for RN, LPN, CNA, Nurse Training, and Family Training.

Reimbursement for Respite (excluding Children's Community-Based Health Center), Certified Nursing Assistant, and In Home Shift Nursing services are expected to increase by 7.0%. The State adjusted the cost per service (CPS) beginning in WY 3 to reflect the reimbursement change.

To reduce the need for future technical amendments, the State assumed reimbursement for these services will increase by approximately 6.4% at the start of each calendar year in WYs 4 and 5. Annual increases in the CPS were developed based on a review of the annual changes in the CPS for In Home Shift Nursing services between January 1, 2021, and January 1, 2025.

The State also assumed the CPS for Children's Community-Based Health Center, and Family Training services will increase by approximately 6.4% at the start of each calendar year in WYs 4 and 5, assuming the services would trend similarly to In Home Shift Nursing.

The amendment also added Adaptive Equipment as a new waiver service.

The waiver will cover the costs of devices, controls, or appliances that enable customers to perceive, control, access, and/or communicate with the environment in which they live, as well as perform activities of daily living.

To estimate the costs of this service, the State began by developing a CPS estimate using the Adaptive Equipment experience from the Children's Support Waiver (CSW) (IL.0464) between September 2022, and August 2023. Adaptive Equipment was a covered service in the CSW during that time period and the population covers similar age groups. The State trended the CPS estimate to the midpoint of the amended WYs. Annual trend assumptions of approximately 3.3% were developed using data compiled by the Bureau of Labor Statistics and represent the average change in price of all goods between 2022 and 2023 in Chicago, IL, Naperville, IL, Elgin, IL, Illinois, Indiana, and Wisconsin.

The State assumed approximately 1.3 units per user in each WY based on CSW assumptions. The State projects 10 users per WY, based on CSW assumptions.

This amendment also added Assistive Technology as a new waiver service.

The waiver will cover the costs of an item, piece of equipment, or product, whether bought, made, or modified, that is used to increase, maintain, or improve a customer's functional capabilities.

To estimate the costs of this service, the State assumed the CPS in each waiver year will be twice as much as the Adaptive Equipment CPS, which is consistent with relative cost assumptions in the CSW. The State assumed 10 users in each WY and 1.3 units per user, based on assumptions from the CSW.

This amendment also breaks out services currently grouped up the Environmental Accessibility Adaptations service umbrella into separate services. The waiver will reflect the following services separately:

- Home Accessibility Modification
- Medical Equipment and Operating Expenses
- Pest Control
- Vehicle Modifications

These are existing waiver services that were previously rolled into Environmental Accessibility Adaptations. Since the onset of the public health emergency, experience for these services has been materially higher than previous projections. The State is revising the waiver to reflect the increased utilization.

The State used CY 2023 MFTD experience as the base data for future waiver years and trended utilization and cost per service. For Medical Equipment and Operating Expenses, Pest Control, and Vehicle Modifications, utilizer trend assumptions are equivalent to the annualized change in users between CY 2021 and CY 2023. Trend assumptions for Home Accessibility Modifications are equivalent to estimated annualized change in users between CY 2022 and June 2024. The State used a different period for Home Accessibility Modifications because utilization more than doubled between CY 2021 and CY 2022 when generators were added as a covered service.

Approximate trend estimates for each waiver service are listed below:

- Home Accessibility Modification – 5.8%
- Medical Equipment and Operating Expenses – 24.8%
- Pest Control – 4.8%
- Vehicle Modifications – 17.3%

Consistent with Adaptive Equipment, the State assumed an annual trend of approximately 3.3%. The State assumed one unit per user for each service.

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:

In the development of this waiver renewal, the previously submitted CMS 372 reports were found to be overstated. Instead of relying on the submitted 372 reports, estimates were developed using claims and enrollment data in the State's MMIS systems for September 2017 through March 2022. The experience for non-waiver services for MFTD Waiver enrollees was summarized for WY3. The summary is similar to 372 reports, except all runout is through March 2022 rather than six or eighteen months.

To develop Factor D' estimates for the new waiver years, the following adjustments were applied to the historical experience for non-waiver services:

- 1.2% annual per capita trend, based upon trends and program changes applicable to the disabled adult population in CY2022 HealthChoice capitation rate development.

- An adjustment to normalize for the change in ALOS between waiver years.

-An adjustment to reflect fee schedule changes for In Home Shift Nursing and CNA services, which are covered under the state plan for customers under age 21.

The same methodology was used to project trends for Factor D', Factor G, and Factor G'. We leveraged CY 2022 capitation rate development for annual trend assumptions by major service category. A composite trend was developed by applying those trend rates to CY 2019 base experience for the Factor D', Factor G, and Factor G' services. The slightly larger observed trend from WY1 to WY2 is a result of the existence of a leap day in WY2.

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:

In the development of this waiver renewal, the previously submitted CMS 372 reports were found to be overstated. Instead of relying on the submitted 372 reports, estimates were developed using claims and enrollment data in the State's MMIS system through March 2022. The experience for three level of care sub-populations was summarized for WY3. In doing so, hospital and nursing facility claims were assigned to Factor G and remaining claims were assigned to Factor G'. The summary is similar to 372 reports, except all runout is through March 2022 rather than six or eighteen months.

For purposes of developing cost neutrality, the participating MFTD population was segmented into three level of care sub-populations that have varying level of needs and cost profiles. The three level of care sub-populations are:

- Hospital*
- Nursing Facility – Under 21 Years*
- Nursing Facility – 21+ Years*

- Hospital – Individuals with a hospital level of care enrolled in the MFTD waiver subsequent to WY3.*

- Nursing Facility Under 21 Years – Individuals under age 21 residing in pediatric nursing facilities, identified based upon a list of provider IDs.*

- Nursing Facility 21+ Years – Individuals ages 21 and older requiring ventilator care or tracheostomy care in a nursing facility.*

To develop Factor G estimates for the new waiver years, annual per capita trends and an adjustment to normalize for the change in ALOS between waiver years were applied to the historical experience by sub-population.

Trend for Factor G: Hospital (1.0%), Nursing Facility Under 21 Years (2.4%), and Nursing Facility 21+ Years (2.4%).

Trend assumptions were based upon trends and program changes applicable to the disabled adult population in CY 2022 HealthChoice capitation rate development. An increase in nursing facility per diems of approximately 20% effective July 2022 was also reflected in the Factor G estimates.

Composite estimates for Factor G for the new waiver years were developed by weighting the estimates for the sub-populations based on recent MFTD waiver enrollment mix (Hospital – 57.0%, Nursing Facility Under 21 Years – 39.5%, Nursing Facility 21+ Years – 3.5%).

The same methodology was used to project trends for Factor D', Factor G, and Factor G'. We leveraged CY 2022 capitation rate development for annual trend assumptions by major service category. A composite trend was developed by applying those trend rates to CY 2019 base experience for the Factor D', Factor G, and Factor G' services. The slightly larger observed trend from WY1 to WY2 is a result of the existence of a leap day in WY2.

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:*

In the development of this waiver renewal, the previously submitted CMS 372 reports were found to be overstated. Instead of relying on the submitted 372 reports, estimates were developed using claims and enrollment data in the State's MMIS system through March 2022. The experience for three level of care sub-populations was summarized for WY3. In doing so, hospital and nursing facility claims were assigned to Factor G and remaining claims were assigned to Factor G'. The summary is similar to 372 reports, except all runout is through March 2022 rather than six or eighteen months.

For purposes of developing cost neutrality, the participating MFTD population was segmented into three level of care sub-populations that have varying level of needs and cost profiles. The three level of care sub-populations are:

- Hospital
- Nursing Facility – Under 21 Years
- Nursing Facility – 21+ Years
- Hospital – Individuals with a hospital level of care enrolled in the MFTD waiver subsequent to WY3.
- Nursing Facility Under 21 Years – Individuals under age 21 residing in pediatric nursing facilities, identified based upon a list of provider IDs.
- Nursing Facility 21+ Years – Individuals ages 21 and older requiring ventilator care or tracheostomy care in a nursing facility.

To develop Factor G' estimates for the new waiver years, annual per capita trends and an adjustment to normalize for the change in ALOS between waiver years were applied to the historical experience by sub-population.

Trend for Factor G': Hospital (3.1%), Nursing Facility Under 21 Years (4.2%), and Nursing Facility 21+ Years (4.3%).

Trend assumptions were based upon trends and program changes applicable to the disabled adult population in CY 2022 HealthChoice capitation rate development.

Composite estimates for Factor G' for the new waiver years were developed by weighting the estimates for the sub-populations based on recent MFTD waiver enrollment mix (Hospital – 57.0%, Nursing Facility Under 21 Years – 39.5%, Nursing Facility 21+ Years – 3.5%).

The same methodology was used to project trends for Factor D', Factor G, and Factor G'. We leveraged CY 2022 capitation rate development for annual trend assumptions by major service category. A composite trend was developed by applying those trend rates to CY 2019 base experience for the Factor D', Factor G, and Factor G' services. The slightly larger observed trend from WY1 to WY2 is a result of the existence of a leap day in WY2.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Respite	
Adaptive Equipment	
Assessment by Occupational or Physical Therapist	
Assistive Technology	
Certified Nursing Assistant (CNA)	
Environmental Accessibility Adaptations	
Family Training	
Home Accessibility Modifications	

Waiver Services	
In-Home Shift Nursing	
Nurse Training	
Pest Control	
Placement Maintenance Counseling Services	
Specialized Medical Equipment and Supplies	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						2648872.50
Respite - RN	hour	287	90.50	45.00	1168807.50	
Respite - LPN	hour	298	93.50	37.50	1044862.50	
Respite - CNA	hour	24	71.90	25.00	43140.00	
Children's Community-Based Health Center	hour	25	348.50	45.00	392062.50	
Adaptive Equipment Total:						0.00
Adaptive Equipment	per item	0	0.00	0.01	0.00	
Assessment by Occupational or Physical Therapist Total:						0.00
Assessment by Occupational or Physical Therapist	Hour	0	0.00	0.01	0.00	
Assistive Technology Total:						0.00
Assistive Technology	per item	0	0.00	0.01	0.00	
Certified Nursing Assistant (CNA) Total:						594580.00
Certified Nursing Assistant (CNA)	hour	14	1698.80	25.00	594580.00	
GRAND TOTAL: 21963855.82 Total Estimated Unduplicated Participants: 1588 Factor D (Divide total by number of participants): 13831.14 Average Length of Stay on the Waiver: 321						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:						1190766.82
Environmental Accessibility Adaptations	unit	509	1.80	1299.68	1190766.82	
Family Training Total:						3000.00
Family Training	hour	5	12.00	50.00	3000.00	
Home Accessibility Modifications Total:						0.00
Home Accessibility Modifications	unit	0	0.00	0.01	0.00	
In-Home Shift Nursing Total:						17425063.50
RN	hour	128	1497.60	45.00	8626176.00	
LPN	hour	130	1804.90	37.50	8798887.50	
Nurse Training Total:						92259.00
RN	hour	189	6.30	45.00	53581.50	
LPN	hour	191	5.40	37.50	38677.50	
Pest Control Total:						0.00
Pest Control	unit	0	0.00	0.01	0.00	
Placement Maintenance Counseling Services Total:						4314.00
Placement Maintenance Counseling Services	Hour	5	10.00	86.28	4314.00	
Specialized Medical Equipment and Supplies Total:						5000.00
Specialized Medical Equipment and Supplies	unit	5	1.00	1000.00	5000.00	
Vehicle Modifications Total:						0.00
Vehicle Modifications	unit	0	0.00	0.01	0.00	
GRAND TOTAL: 21963855.82 Total Estimated Unduplicated Participants: 1588 Factor D (Divide total by number of participants): 13831.14 Average Length of Stay on the Waiver: 321						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						2858649.00
Respite - RN	hour	307	91.30	45.00	1261309.50	
Respite - LPN	hour	318	94.30	37.50	1124527.50	
Respite - CNA	hour	25	72.60	25.00	45375.00	
Children's Community-Based Health Center	hour	27	351.80	45.00	427437.00	
Adaptive Equipment Total:						0.00
Adaptive Equipment	per item	0	0.00	0.01	0.00	
Assessment by Occupational or Physical Therapist Total:						0.00
Assessment by Occupational or Physical Therapist	Hour	0	0.00	0.01	0.00	
Assistive Technology Total:						0.00
Assistive Technology	per item	0	0.00	0.01	0.00	
Certified Nursing Assistant (CNA) Total:						643012.50
Certified Nursing Assistant (CNA)	hour	15	1714.70	25.00	643012.50	
Environmental Accessibility Adaptations Total:						1304460.86
Environmental Accessibility Adaptations	unit	544	1.80	1332.17	1304460.86	
Family Training Total:						3025.00
Family Training	hour	5	12.10	50.00	3025.00	
Home Accessibility Modifications Total:						0.00
Home Accessibility Modifications	unit	0	0.00	0.01	0.00	
In-Home Shift Nursing Total:						19155318.75
GRAND TOTAL: 24074199.25 Total Estimated Unduplicated Participants: 1696 Factor D (Divide total by number of participants): 14194.69 Average Length of Stay on the Waiver: 324						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
RN	hour	140	1511.60	45.00	9523080.00	
LPN	hour	141	1821.70	37.50	9632238.75	
Nurse Training Total:						100251.00
RN	hour	202	6.40	45.00	58176.00	
LPN	hour	204	5.50	37.50	42075.00	
Pest Control Total:						0.00
Pest Control	unit	0	0.00	0.01	0.00	
Placement Maintenance Counseling Services Total:						4357.14
Placement Maintenance Counseling Services	Hour	5	10.10	86.28	4357.14	
Specialized Medical Equipment and Supplies Total:						5125.00
Specialized Medical Equipment and Supplies	unit	5	1.00	1025.00	5125.00	
Vehicle Modifications Total:						0.00
Vehicle Modifications	unit	0	0.00	0.01	0.00	
GRAND TOTAL: 24074199.25 Total Estimated Unduplicated Participants: 1696 Factor D (Divide total by number of participants): 14194.69 Average Length of Stay on the Waiver: 324						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						3805550.30
GRAND TOTAL: 34525816.11 Total Estimated Unduplicated Participants: 1804 Factor D (Divide total by number of participants): 19138.48 Average Length of Stay on the Waiver: 326						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite - RN	hour	326	91.90	56.52	1693305.29	
Respite - LPN	hour	339	94.90	47.10	1515258.81	
Respite - CNA	hour	27	73.00	31.40	61889.40	
Children's Community-Based Health Center	hour	28	353.90	54.00	535096.80	
Adaptive Equipment Total:						30550.00
Adaptive Equipment	per item	10	1.30	2350.00	30550.00	
Assessment by Occupational or Physical Therapist Total:						0.00
Assessment by Occupational or Physical Therapist	Hour	0	0.00	0.01	0.00	
Assistive Technology Total:						61100.00
Assistive Technology	per item	10	1.30	4700.00	61100.00	
Certified Nursing Assistant (CNA) Total:						866740.48
Certified Nursing Assistant (CNA)	hour	16	1725.20	31.40	866740.48	
Environmental Accessibility Adaptations Total:						0.00
Environmental Accessibility Adaptations	unit	0	0.00	0.01	0.00	
Family Training Total:						3830.56
Family Training	hour	6	12.20	52.33	3830.56	
Home Accessibility Modifications Total:						1836626.82
Home Accessibility Modifications	unit	322	1.00	5703.81	1836626.82	
In-Home Shift Nursing Total:						26275260.64
RN	hour	152	1520.90	56.52	13066112.74	
LPN	hour	153	1833.00	47.10	13209147.90	
Nurse Training Total:						1075528.50
RN					625817.70	
GRAND TOTAL: 34525816.11 Total Estimated Unduplicated Participants: 1804 Factor D (Divide total by number of participants): 19138.48 Average Length of Stay on the Waiver: 326						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	hour	215	51.50	56.52		
LPN	hour	217	44.00	47.10	449710.80	
Pest Control Total:						38038.82
Pest Control	unit	109	1.00	348.98	38038.82	
Placement Maintenance Counseling Services Total:						5280.34
Placement Maintenance Counseling Services	Hour	6	10.20	86.28	5280.34	
Specialized Medical Equipment and Supplies Total:						6303.78
Specialized Medical Equipment and Supplies	unit	6	1.00	1050.63	6303.78	
Vehicle Modifications Total:						521005.88
Vehicle Modifications	unit	29	1.00	17965.72	521005.88	
GRAND TOTAL: 34525816.11 Total Estimated Unduplicated Participants: 1804 Factor D (Divide total by number of participants): 19138.48 Average Length of Stay on the Waiver: 326						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						4318872.29
Respite - RN	hour	346	92.40	60.26	1926536.30	
Respite - LPN	hour	359	95.50	50.22	1721767.59	
Respite - CNA					68901.84	
GRAND TOTAL: 40111161.06 Total Estimated Unduplicated Participants: 1912 Factor D (Divide total by number of participants): 20978.64 Average Length of Stay on the Waiver: 328						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	hour	28	73.50	33.48		
Children's Community-Based Health Center	hour	30	356.10	56.32	601666.56	
Adaptive Equipment Total:						31566.34
Adaptive Equipment	per item	10	1.30	2428.18	31566.34	
Assessment by Occupational or Physical Therapist Total:						1110.00
Assessment by Occupational or Physical Therapist	hour	10	1.00	111.00	1110.00	
Assistive Technology Total:						63132.68
Assistive Technology	per item	10	1.30	4856.36	63132.68	
Certified Nursing Assistant (CNA) Total:						1385127.86
Certified Nursing Assistant (CNA)	hour	53	780.60	33.48	1385127.86	
Environmental Accessibility Adaptations Total:						0.00
Environmental Accessibility Adaptations	unit	0	0.00	0.01	0.00	
Family Training Total:						4118.04
Family Training	hour	6	12.30	55.80	4118.04	
Home Accessibility Modifications Total:						2009707.37
Home Accessibility Modifications	unit	341	1.00	5893.57	2009707.37	
In-Home Shift Nursing Total:						30404998.45
RN	hour	164	1530.30	60.26	15123403.99	
LPN	hour	165	1844.20	50.22	15281594.46	
Nurse Training Total:						1220264.82
RN	hour	227	51.80	60.26	708573.24	
LPN	hour	230	44.30	50.22	511691.58	
Pest Control Total:						41107.26
GRAND TOTAL: 40111161.06 Total Estimated Unduplicated Participants: 1912 Factor D (Divide total by number of participants): 20978.64 Average Length of Stay on the Waiver: 328						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Pest Control	unit	114	1.00	360.59	41107.26	
Placement Maintenance Counseling Services Total:						0.00
Placement Maintenance Counseling Services	Hour	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies Total:						0.00
Specialized Medical Equipment and Supplies	unit	0	0.00	0.01	0.00	
Vehicle Modifications Total:						631155.94
Vehicle Modifications	unit	34	1.00	18563.41	631155.94	
GRAND TOTAL: 4011161.06 Total Estimated Unduplicated Participants: 1912 Factor D (Divide total by number of participants): 20978.64 Average Length of Stay on the Waiver: 328						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						4891063.12
Respite - RN	hour	365	93.00	64.15	2177571.75	
Respite - LPN	hour	379	96.10	53.46	1947114.77	
Respite - CNA	hour	30	73.90	35.64	79013.88	
Children's Community-Based Health Center	hour	32	358.30	59.95	687362.72	
Adaptive Equipment Total:						32616.48
GRAND TOTAL: 47964183.40 Total Estimated Unduplicated Participants: 2020 Factor D (Divide total by number of participants): 23744.65 Average Length of Stay on the Waiver: 330						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptive Equipment	per item	10	1.30	2508.96	32616.48	
Assessment by Occupational or Physical Therapist Total:						1110.00
Assessment by Occupational or Physical Therapist	hour	10	1.00	111.00	1110.00	
Assistive Technology Total:						65232.96
Assistive Technology	per item	10	1.30	5017.92	65232.96	
Certified Nursing Assistant (CNA) Total:						3361051.58
Certified Nursing Assistant (CNA)	hour	54	1746.40	35.64	3361051.58	
Environmental Accessibility Adaptations Total:						0.00
Environmental Accessibility Adaptations	unit	0	0.00	0.01	0.00	
Family Training Total:						4383.72
Family Training	hour	6	12.30	59.40	4383.72	
Home Accessibility Modifications Total:						2198360.04
Home Accessibility Modifications	unit	361	1.00	6089.64	2198360.04	
In-Home Shift Nursing Total:						35237375.55
RN	hour	177	1539.60	64.15	17481465.18	
LPN	hour	179	1855.50	53.46	17755910.37	
Nurse Training Total:						1380221.31
RN	hour	240	52.10	64.15	802131.60	
LPN	hour	243	44.50	53.46	578089.71	
Pest Control Total:						44710.80
Pest Control	unit	120	1.00	372.59	44710.80	
Placement Maintenance Counseling Services Total:						0.00
Placement					0.00	
GRAND TOTAL: 47964183.40 Total Estimated Unduplicated Participants: 2020 Factor D (Divide total by number of participants): 23744.65 Average Length of Stay on the Waiver: 330						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Maintenance Counseling Services	Hour	0	0.00	0.01		
Specialized Medical Equipment and Supplies Total:						0.00
Specialized Medical Equipment and Supplies	unit	0	0.00	0.01	0.00	
Vehicle Modifications Total:						748057.83
Vehicle Modifications	unit	39	1.00	19180.97	748057.83	
GRAND TOTAL: 47964183.40 Total Estimated Unduplicated Participants: 2020 Factor D (Divide total by number of participants): 23744.65 Average Length of Stay on the Waiver: 330						