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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The proposed renewal for the Persons who are Elderly waiver contains a few changes from the current waiver. The narrative below explains the significant differences.

1. All appendices were updated for accuracy and to streamline narratives.

2. Edited Main-2 and Appendix A-3 to remove the reference to the Medicare Medicaid Alignment Initiative (MMAI) which ended 12/31/2025 and replaced with the Dual Eligible Special Needs Plan program (D-SNP) model, which is called the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), and became effective 1/1/2026.

3. Edited C-2-b to reflect the State's addition of an abuse registry screening process.

4. Edited Appendices C-2-e, C-5, D-1-d, D-1-ii, and D-2-a to reflect changes resulting from the 3.7 software change.

5. Edited Appendices F-3-b and F-3-c to include updated grievance procedures which meet the requirements in the Federal HCBS Access Rule implementation deadline of 7/1/2026.

6. Edited Appendix I-2-a to reflect the current provider rates for the renewal.

7. Edited Appendix J for waiver capacity and overall cost estimates for the 5-year waiver period.

8. Removed all references indicating that quality assurance record reviews will be done onsite by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO). All record reviews will be done remotely and will continue to ensure compliance with performance measures as well as with all applicable state and federal requirements, and MCO contractual requirements.

9. Edited Appendix B-3-a to update the phase-in/phase-out enrollment numbers for the 5-year waiver renewal period.

10. Edited Performance Measures to reflect accurate data sources, the responsible party for data collection/generation, the frequency of data collection/generation, sampling approach, and responsible party for data aggregation and analysis, and the frequency of data aggregation and analysis. All data sources previously indicated "Record Review On site" have been changed to just "Record Review" to reflect the State's change from on-site reviews to record reviews.

11. Edited Performance Measures A5 and A6 to delete fee-for-service (FFS) customers from the PMs.

12. Added Performance Measures A7 and A8 to capture fee-for-service (FFS) customers.

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*):

Persons who are Elderly

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IL.0143
Draft ID: IL.020.08.00

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

Regular Waiver

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

10/01/26

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:

Customers aged 60 or above.

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

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

☒ **Waiver(s) authorized under section 1915(b) of the Act.**

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

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

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

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

☒ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☒ **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

The State enrolls Medicaid customers on a mandatory basis into Managed Care Organizations (MCOs) through the HealthChoice Illinois, which is a full-risk capitated program.

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

☐ **A program authorized under section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

☒ **A program authorized under section 1115 of the Act.**

Specify the program:

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

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives,

organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Department of Healthcare and Family Services (HFS), the state Medicaid Agency (MA), has delegated the day-to-day operations for the waiver to the Illinois Department on Aging (IDoA), the Operating Agency (OA). Responsibilities of each agency are defined in an interagency agreement. The OA is the lead agency for community-based services and supports to Illinois residents, 60+ years of age. The OA is responsible for eligibility, person-centered plan (PCP) development and implementation, enrolling waiver providers, reporting to the MA, and assuring services and providers meet established standards. The MA enrolls providers in Medicaid, provides oversight, consultation and monitoring, processes federal claims and maintains an appeal process.

The waiver is part of the Community Care Program (CCP), a larger state program operated by the OA since 1979. The CCP offers services to customers age 60+ who meet functional and financial eligibility. Those that meet Medicaid eligibility are waiver customers. Those that do not meet Medicaid eligibility are funded with state only monies. Customers may transition in and out of Medicaid eligibility. Services offered are the same for both Medicaid and state funded customers. The percentage of Medicaid waiver customers in the CCP is 75%. This includes both MCO and fee-for-service populations.

There are 13 Planning and Service Areas (PSA) in Illinois, each managed and served by an Area Agency on Aging (AAA). The OA works in partnership with these not-for-profit corporations and one unit of local government, the City of Chicago. AAAs provide planning and coordination of Older American Act (OAA) services and programs in their respective geographic areas.

An entity called the Community Care Program Advisory Committee (CCPAC) advises the OA on an ongoing basis on reimbursement rates for CCP services, and recommendations regarding issues affecting CCP service delivery and quality. Composition requires representatives from AAAs, Care Coordination Units (CCU), providers, advocates, adults over age 60 and state agencies. The MA attends all CCPAC meetings and actively participates to clarify Medicaid or waiver policy.

Customer need for CCP services is determined by local community agencies, Care Coordination Units (CCUs), which are under contract with the OA. Care Coordinators are employed by CCUs. Care Coordinators practice a person-centered approach to assessment, care planning and on-going care coordination. Customers are provided with the opportunity to lead the PCP process. Those that choose not to are still engaged at all levels of assessment and care planning. Care Coordinators evaluate applicants need for long term service and supports (LTSS) using a standardized needs assessment instrument, the Determination of Need (DON). This tool is part of a comprehensive care assessment and designed to identify all needs and risks of the customer, including health and well-being, social determinants of health, depression, suicide, substance abuse, and support to and from caregivers. In addition, all nursing facility applicants are evaluated prior to admission and, if eligible, are offered the option of community based LTSS. Customers in CCP 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 CCP services. Services available under the waiver include homemaker, adult day service, emergency home response service, and automated medication dispenser. Other services are available through the Older Americans Act (OAA) and the aging network and may be included in the PCP in addition to waiver services.

The OA uses all willing and qualified providers for providers seeking certification. OA staff ensure that providers meet all standards being certified and before a contract is issued.

The MA and the OA maintain separate but complementary processes to monitor customer welfare, service access, and quality. The OA provides the MA with reports of their monitoring activities, including sanctions. The OA responds to the MA's reports from data obtained in site visits and file reviews conducted by federally approved Quality Improvement Organizations. Negative findings are addressed with corrective actions. The MA and OA meet quarterly to discuss reports that identify problematic trends and track the effects of remediation efforts to improve performance.

Illinois' mandatory managed care program, called HealthChoice Illinois, began operating statewide effective January 1, 2018. Starting January 1, 2026, customers can enroll in the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). This program replaces the Medicare Medicaid Alignment Initiative which ended December 31, 2025. FIDE SNP customers are not impacted by HealthChoice Illinois.

3. Components of the Waiver Request

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

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

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

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

geographic area:

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver

and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

The State solicited public input for this waiver renewal in several ways. The public comment period began XXXX and concluded on XXXXX.

On XXXXXXX the State Medicaid Agency posted on its public website a draft of the proposed waiver renewal. That link is: https://hfs.illinois.gov/medicalclients/hcbs.html

This proposed waiver renewal is also provided via a non-electronic method of public distribution. A copy of the proposed amendment was posted at DHS local offices throughout the state, except in Cook County. In Cook County, the notice is available 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 Illinois Department an Aging, the Operating Agency for the HCBS Waiver for Persons who are Elderly, emailed notification 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 renewal will remain on the public website until final approval from CMS.

The State issued tribal notification on XXXXXXX.

The State received XXXX comments during the public comment period.

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: Senior Public Service Administrator

Agency: Healthcare and Family Services

Address: 201 South Grand Avenue

Address 2:

City: Springfield

State: **Illinois**

Zip: 62763

Phone: (217) 782-6359 **Ext:** ☐ **TTY**

Fax: (217) 557-2349

E-mail: Pamela.Winsel@illinois.gov

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

Last Name: Hedges

First Name: Derek

Title: Division Manager, Planning, Research, Development and Training

Agency: Illinois Department on Aging

Address: One Natural Resources Way, Suite 100

Address 2:

City: Springfield

State: **Illinois**

Zip:

62702-1271

Phone:

(217) 785-3385 **Ext:** ☐ **TTY**

Fax:

(217) 782-4477

E-mail:

Derek.R.Hedges@illinois.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

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:

Phelan

First Name:

Laura

Title:

Medicaid Administrator

Agency:

Healthcare and Family Services

Address:

401 South Clinton

Address 2:

City:

Chicago

State: **Illinois**

Zip:

60607

Phone:

(312) 515-6768 **Ext:** ☐ **TTY**

Fax:

(312) 793-1640

E-mail:

Laura.Phelan@illinois.gov

Attachments

Attachment #1: Transition Plan

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

☒ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

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

☐ **Reducing the unduplicated count of participants (Factor C).**

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

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

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

Specify the transition plan for the waiver:

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

CONTINUED FROM APPENDIX F-1:
Fair Hearing by Medicaid Agency (MA):

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

Customers who file an appeal within 60 calendar days of notice of the adverse action are notified that services will continue through the appeal process via the OA appeal action notice, which states that the level of service is being continued until the appeal is complete, unless an exception applies. Fair hearing documents, including notices of adverse actions and requests for a Fair Hearing, are maintained by OA.

Example of when a customer may request a fair hearing:

1. A decision to deny, reduce, terminate, or in any way change services or how those services are provided. If the decision to reduce, terminate or in any way change services is based on automatic, non-discretionary changes in eligibility, rates or benefits required by federal or State statute or regulation, which adversely affects some or all customers, the appeal will be automatically denied, and the customer affected will not be afforded a hearing.

2. A decision to deny a request for redetermination of eligibility.

3. Failure to make a decision or take appropriate action on any reasonable request made by a customer within 15 calendar days after the date of the request.

4. The outcome of the determination of the eligibility for nursing facility level of care or the supportive living program setting.

Advocacy:

The State Long-Term Care Ombudsman Program (LTCOP) was initially designed to protect and promote the rights and quality of life for customers who reside in LTC facilities. The LTCOP was expanded to advocate for people aged 60 and older, and disabled adults between the ages of 18-59 who receive FIDE-SNP or services through one of the Medicaid Home and Community Based Services (HCBS) waivers.

The Home Care Ombudsman Program (HCOP) was developed to provide services to customers receiving home and community-based services through the OA or MCO. A Home Care Ombudsman may assist a customer who has requested assistance with grievances and appeals and may represent a customer in a fair hearing. In order to do this, the customer must provide consent by completing the Authorized Representative Form.

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:

Illinois Department on Aging

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 Home and Community Based Services (HCBS) waiver responsibilities of both agencies. The OA is responsible for customer eligibility, person-centered plan (PCP) development, Community Care Program (CCP) budgeting, enrolling and certifying waiver providers, assuring PCPs are implemented and that services and providers meet standards established in the approved waiver and governing rules. The MA enrolls providers in Medicaid, provides oversight, consultation and monitoring of waiver operations, processes federal claims, and maintains an appeal process. The interagency agreement is reviewed at least annually and updated as needed. The MA's Waiver Unit reviews all of the OA's rules and policies prior to them being presented to the MA's Medical Policy Review Committee for final review and approval.

The MA conducts routine oversight monitoring of the fiscal and program activities to assure the State meets the federal assurances identified in the waiver. The MA contracts with a federally certified Quality Improvement Organization (QIO) for Fee-For-Service (FFS) customers and an External Quality Review Organization (EQRO) for managed care customers to assist the MA in its role of an administrative oversight for the Persons who are Elderly Waiver. The MA randomly selects the customer sample from the Medicaid Management Information System (MMIS) using claims for waiver services in a specific time period.

The MA and the state's QIO and EQRO provide quality oversight and monitoring of the waiver providers through record review audits of the customer PCP and reviewing the quality of services and supports provided to the HCBS program customers.

The state's QIO and EQRO perform record reviews to evaluate compliance with waiver performance measures as well as certain contractual components. The QIO and EQRO utilize tools that evaluate the following waiver assurances:

Level of Care - Examines customer records to determine completeness and accuracy of the Mini Mental State Exam (MMSE)/Determination of Need (DON) completed by the Care Coordination Unit (CCU). The EQRO ensures the MCOs have the required copy of the current DON score assessed by the CCU in the customer's record.
Qualified Providers - Review of initial Care Coordinator qualifications and training, as well as ongoing annual training. The EQRO also has oversight of MCO Care Coordinator caseloads during the post implementation review and during the administrative compliance reviews.

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, as required.

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

Remediation - The QIO and EQRO will submit a report of findings to the MA at the conclusion of each review. The report will consist 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.
For FFS customers, the OA will track remediation activities to ensure 100% remediation of findings. For MCO customers, remediation activities will be tracked by the EQRO to ensure 100% remediation of findings. Timeframes for completion of remediation will be reported in 30, 60, 90, or greater than 90 days. Remediation activities will be consistent with the approved activities detailed within each Performance Measure. HFS, the OA, and the EQRO will work collaboratively to follow up to ensure remediation occurs within the required time frames.

Sampling—the MA's sampling methodology is based on a statistically valid sampling approach that uses a 95% confidence level and a +/- 5% margin of error.
The MA requires the OA to submit reports related to timeliness of annual eligibility assessments, CIs, APS reports, and any ad hoc reporting requested. OAs discuss the reports during quarterly quality meetings. MCOs are required to submit quarterly reports, using the format required by the MA, on specific performance measures which are described in the MA's contracts with the MCOs. For each performance measure, contracts specify numerators, denominators, sampling approaches, data sources, etc. The OA and MCOs present the results to the MA in quarterly meetings.

The MA holds quarterly meetings with the OA to review program administration, adherence to waiver requirements, and evaluate system performance. Quarterly meetings also discuss broad topics, 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. The MA also holds similar quarterly meetings with each of the MCOs independently to review program administration, adherence to waiver requirements and evaluate system performance. The MA may also meet with all the MCOs collectively when necessary to provide program updates, introduce new services, policies and procedures, etc.

In addition, MA/OA/MCO staff communicate regularly regarding any issues that arise relating to administration of the waiver. These topics include general waiver administration, quality improvement strategies, Access Rule and Electronic Visit Verification, etc.

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.:*

The State contracts with Care Coordination Units (CCU) and Managed Care Organizations (MCO).

CCUs: The OA contracts with CCUs for its Care Coordination services. CCUs perform the initial and ongoing waiver eligibility determinations for both the Fee for Service (FFS) and MCO customers. Person-centered plan (PCP) development, ongoing case management, and monitoring is also the responsibility of the CCUs for FFS customers. For customers enrolled in an MCO, the PCP development, ongoing case management and monitoring is the responsibility of the MCO.

OA CCU Care Coordination functions include:

1) Conduct a comprehensive care assessment of need and eligibility determination initially and at least annually or as needed based on changes in the customer's financial, support or functional needs.

2) Outline available services and choices and provide the customer with information to allow the customer to make informed choices regarding services and providers.

3) Develop a PCP with the customer that best meets customer needs, with available services through the waiver or other funding sources. Provide the opportunity to the customer/representative to lead the planning process.

4) Monitor service implementation.

5) Ensure customer safeguards.

6) Maintain customer records.

7) Complete quality assurance and quality improvement activities.

MCOs: Illinois' mandatory managed care program, called HealthChoice Illinois, began operating statewide effective January 1, 2018. Starting January 1, 2026, customers can enroll in the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). This program replaces the Medicare Medicaid Alignment Initiative which ended December 31, 2025. FIDE SNP customers are not impacted by HealthChoice Illinois.

For those waiver customers enrolled in an MCO, the MCOs will be responsible for care coordination, PCP development and oversight, customer safeguards, prior authorization of waiver services, and quality assurance and quality improvement activities. CCUs perform the initial and ongoing waiver eligibility determinations for MCO members.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

The Operating Agency (OA) is responsible for oversight of the Care Coordination Units (CCUs).

The MA is responsible for assessing the performance of contracted entities in conducting waiver operational and administrative functions. The MA contracts with a Quality Improvement Organization (QIO) to conduct record reviews for the Fee-for-Service (FFS) waiver customers. The MA contracts with an External Quality Review Organization (EQRO) to conduct reviews for Managed Care customers.

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

The MA contracts with a QIO and EQRO to monitor the compliance with waiver assurances. As part of the MA’s quality oversight and monitoring of the waiver providers, the QIO and EQRO perform audits of the customers' PCPs through record reviews. Upon completion of record reviews, the QIO/EQRO provides a customer specific summary of findings by measure and a waiver specific summary report of findings and recommendations as appropriate. The report includes a summary of non-compliance related to specific performance measures; overall summary of record review findings; and recommendations for remediation of non-compliance. The QIO/EQRO produces a quarterly report on PMs based on record reviews. The MA reviews the reports for outliers and poor performing measures. The MA and QIO/EQRO work collaboratively to follow up with the OA or MCOs to ensure 100% remediation occurs within the required time frames. MCO contracts include sanctions for failure to meet requirements for submissions of quality and performance measures.

The MA's ongoing quality monitoring includes sharing reports from QIO and EQRO reviews with the OA as well as directly with the review site/MCO. Both the QIO and EQRO perform remediation validation through random selection to ensure that review findings have been remediated.

In addition, MA/OA/MCO staff communicates regularly regarding any issues that arise relating to the administration of the waiver. These topics include general waiver administration, quality improvement strategies, HCBS Settings Rule, HCBS Access Rule, etc.

The MA holds quarterly meetings with the OA and MCOs to 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. The MA may also meet with all the OAs and MCOs collectively when necessary to provide program updates, introduce new services, policies and procedures, etc.

Appendix A: Waiver Administration and Operation

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

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

The Medicaid Agency (MA) and Operating Agency (OA) maintain separate but complementary processes to monitor customer welfare, service access, and quality. There is some duplication of review criteria for the MA and the OA reviews, but the same exact criteria are not utilized by both, and the reviews are not conducted concurrently.
The annual reviews referenced in this section by the MA are part of continued certification that the CCUs are complying with all administrative rules and policies for the Community Care Program (CCP) which includes the waiver. The OA conducts Quality Improvement Reviews of CCUs on a three-year cycle. The OA conducts periodic conference calls with CCUs to discuss performance related goals and strategies for addressing performance issues.

In addition to this compliance review, the OA provides each CCU with reports that demonstrate each agency's average score on the Determination of Need (DON) tool as well as the customer satisfaction data. These reports compare each CCU's average score with other CCUs in their Planning and Service Area (PSA) and the statewide average. This information is also shared with the MA during quarterly quality assurance meetings.

The MA's monitoring activity is not intended to replicate the OA's reviews. The QIO performs customer record reviews based on a randomly drawn representative sample.

OA’s Oversight of CCUs:

Quarterly:
The OA conducts quarterly monitoring calls with all CCUs. The OA aggregates and analyzes CCU performance data to create management reports for performance and trend analysis of CCUs. The collected data assists the OA to identify potential performance problems for investigation and remediation. CCUs are required to use the feedback obtained by the OA and shared with CCUs as a central component of their own quality management strategy. The OA reviews reports with CCUs individually on a quarterly basis or more frequently if needed.

Monthly:
The OA conducts monitoring calls with CCUs with performance concerns to discuss corrective action strategies, monitor CCU compliance with the corrective action plans, and review performance and trend analysis. Monthly monitoring calls continue until the CCU’s compliance improves and all corrective action activities have been completed.

Annually:
The OA conducts a risk assessment of each CCU. This risk assessment includes a review of performance reports and measures, corrective action taken, the policies and procedures maintained by the CCU, and other items, as appropriate. Based on risk assessment results, the OA selects a sample of CCUs for on-site monitoring each year.

Every three years:
The OA conducts an extensive onsite Quality Improvement Review of each CCU.
The OA may conduct more frequent assessments or reviews based on a variety of reasons that may be the result of customer/family caregiver complaints, billing issues or an event report among others. Additional reviews may also occur if numerous complaints or event reports are received for the same agency. The OA may also conduct a Limited Scope Quality Improvement (QI) onsite review or a Desk Audit at any time during the three-year cycle. The type of review completed is dependent upon the reasons that triggered the need for the review.

MA Oversight of CCUs:

The MA assesses the performance of the CCUs through statewide comprehensive record reviews. The MA annually conducts comprehensive record reviews. The MA randomly selects the customer sample from the Medicaid Management Information System (MMIS) using claims for waiver services in a specific time period. The MA’s sampling methodology is based on a statistically valid sampling methodology with a 95% confidence level and a +/-5% margin of error.

The QIO and EQRO record reviews encompass many areas, such as the timeliness and content of assessments, case notes, PCPs meet customer needs and are person-centered including evidence that customers know how to contact the Care Coordinator and that choice of services and providers were given.

A report of findings is completed and sent to OA and CCU or the MCO after completion of the review, generally within 30 days. Agencies are prescribed a timeframe for completing corrective actions identified in the review. For issues of health, safety and welfare, the timeframe is generally 30 calendar days (or less depending on the severity); for most corrective actions the timeframe is 60 calendar days. The OA may initiate contract action, up to and including termination, for an agency with extensive corrective action expectations or issues that jeopardize health, safety, and welfare of customers. The MA meets quarterly with the OAs and MCOs to assess compliance with the waiver assurances and to identify and analyze trends based on scope and severity. Remediation activities are reviewed and systems improvements, if necessary, are implemented.

Oversight of MCOs:

The State assures the MCOs are complying with the federal assurances and performance measures that fall under the functions delegated to them by the MA. The sources of discovery vary, and the sampling methodology for discovery is based on either a 100% review or the use of a statistically valid proportionate and representative sample. The type of sample used is indicated for each performance measure. The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a +/-5% margin of error.

Once the MA selects the sample, it is provided to the OA and to the MA's External Quality Review Organization (EQRO), the entity responsible for monitoring the MCOs and the Quality Improvement Organization (QIO), the entity responsible for monitoring the CCUs. The EQRO and QIO send a report of findings to the OA, CCUs, and the MCOs. For the performance measures that do not require record reviews, the MCOs send routine reports to the MA. These reports are to contain discovery and remediation activity. Data sources may include the MMIS, the MCOs' Information Systems, and the MCO's critical incident reporting systems, and other data sources as indicated in the waiver.

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
A1: Number and percent of substantive waiver changes where Public Notice and Tribal notifications were completed in accordance with CMS regulations. 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:
MA 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 *(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:

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: Number of QMC meetings where OA quality performance data was reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MA and OA QMC Meeting Log

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MA and OA QMC Meeting Log

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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:
A4: Number and percent of active waiver customers compared to the approved waiver capacity. N: Total number of active waiver customers by waiver year. D: Total number of CMS approved waiver slots by waiver year.

Data Source (Select one):

Other
If 'Other' is selected, specify:
MMIS, Enterprise data warehouse

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A5: # and % of MCO waiver customers receiving services in their home or community who state they are able to participate in meaningful activities that help meet their goals/needs. N: # of MCO waiver customers receiving services in their home or community who state they are able to participate meaningful activities that help meet their goals/needs. D: Total # of MCO customers reviewed.

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

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:
A6: Number and percent of MCO waiver customers who state they feel supported in making decisions to remain independent to the greatest extent possible. N: Number of MCO waiver customers who state they feel supported in making decisions to remain independent to the greatest extent possible. D: Total number of MCO customers reviewed.

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

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:
A7: # and % of OA survey respondents receiving services in their home or community who reported they are able to participate in meaningful activities that help meet their

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

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

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

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

Performance Measure:
A8: Number and percent of OA survey respondents who reported they feel supported in making decisions to remain independent to the greatest extent possible. N: Number of OA survey respondents who reported they feel supported in making decisions to remain independent to the greatest extent possible. D: Total number of OA survey respondents.

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

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

	☐ **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.

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 the MA. The MA follows up to completion.

A2: The MA will require completion of overdue reports. The OA will submit the overdue report within 30 days.

A3: The MA will require completion of overdue reports. The MCO will submit the overdue report within 30 days.

A4: 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.

A5: If customers indicate they are unable to participate in meaningful activities, the MCO Care Coordinator will conduct and document follow-up activities to ensure customer satisfaction. Initial follow-up will occur within 30 days of the finding.

A6: If customers indicate they are unable to participate in meaningful activities, the MCO Care Coordinator will conduct and document follow-up activities to ensure customer satisfaction. Initial follow-up will occur within 30 days of the finding.

A7: If customers indicate they are unable to participate in meaningful activities, the OA Care Coordinator will conduct and document follow-up activities to ensure customer satisfaction. Initial follow-up will occur within 30 days of the finding.

A8: If customers indicate they are unable to participate in meaningful activities, the OA Care Coordinator will conduct and document follow-up activities to ensure customer satisfaction. Initial follow-up will occur within 30 days of the finding.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	60	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

1. Be a U. S. citizen or legal alien

2. Be a resident of the State of Illinois.

3. Be over age 60 at the time of application.

4. Be Medicaid eligible.

5. Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment. Must meet the DON threshold of 29 to be eligible for the waiver and/or nursing home placement and a maximum of 100 DON score.

6. Estimated cost to the State for home care is less than estimated cost for institutional care.

7. Can be safely maintained in the home or community-based setting with the services provided in the plan of care.

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

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's**

maximum age limit.

Specify:

Customers who enter the waiver between the ages of 60 and 64 experience no discontinuity of service when they turn 65. Available services are the same for all waiver customers and are based on DON score not on age. After the age of 65 there is no maximum age limit for the waiver.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ○ **Other**

    Specify:

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

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

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

Upon administration of the DON, the methodology establishes a score. An individual point count on the DON is linked to a SCM. This methodology allows each individual DON score a specific SCM rather than a range of DON scores associated to one SCM.

The state may periodically update SCMs based on factors such as changes in provider rates or other factors that impact the cost of waiver services.
All waiver services except the installation of the Automated Medical Dispenser (AMD) and the Emergency Home Response System (EHRS) are included in the SCM. However, the monthly rates are included.

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

◉ **Other:**

Specify:

The installation of the AMD and the EHRS are not included in the SCM, however, the monthly rates for each service are included in the SCM.
The new methodology establishes monthly SCMs based on individual DON scores instead of a range of scores. The result is that each individual DON score has a specific monthly SCM rather than a range of DON scores linking up to one SCM.

DON = DON Score
INH SCM = In-Home Service SCM

ADS SCM = Adult Day Service SCM. SCMs Effective 1/1/2026

DON Score	INH SCM	ADS SCM
29	$786	$1,597
30	$878	$1,855
31	$972	$2,131
32	$1,064	$2,403
33	$1,155	$2,679
34	$1,250	$2,952
35	$1,342	$3,120
36	$1,433	$3,284
37	$1,525	$3,451
38	$1,618	$3,615
39	$1,709	$3,782
40	$1,804	$3,951
41	$1,895	$4,115
42	$1,986	$4,282
43	$2,082	$4,448
44	$2,174	$4,614
45	$2,268	$4,782
46	$2,356	$4,948
47	$2,451	$5,114
48	$2,543	$5,279
49	$2,634	$5,446
50	$2,728	$5,613
51	$2,820	$5,779
52	$2,912	$5,945
53	$3,005	$6,110
54	$3,092	$6,277
55	$3,188	$6,444
56	$3,281	$6,606
57	$3,375	$6,775
58	$3,465	$6,941
59	$3,560	$7,109
60	$3,651	$7,274
61	$3,742	$7,439
62	$3,836	$7,606
63	$3,931	$7,771
64	$4,020	$7,940
65	$4,113	$8,103
66	$4,208	$8,271
67	$4,297	$8,440
68	$4,390	$8,602
69	$4,482	$8,772
70	$4,573	$8,938
71	$4,668	$9,102
72	$4,760	$9,270

73	$4,850	$9,437
74	$4,945	$9,601
75	$5,038	$9,768
76	$5,130	$9,934
77	$5,222	$10,100
78	$5,314	$10,269
79	$5,407	$10,433
80	$5,497	$10,598
81	$5,592	$10,764
82	$5,684	$10,932
83	$5,776	$11,097
84	$5,869	$11,263
85	$5,963	$11,432
86	$6,053	$11,594
87	$6,145	$11,762
88	$6,238	$11,928
89	$6,329	$12,092
90	$6,423	$12,261
91	$6,517	$12,424
92	$6,605	$12,593
93	$6,700	$12,761
94	$6,795	$12,923
95	$6,884	$13,093
96	$6,976	$13,259
97	$7,071	$13,424
98	$7,160	$13,591
99	$7,254	$13,757
100	$7,349	$13,923

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:

A comprehensive needs assessment tool is used to determine customer's goals, strengths, risks, needs and preferences for services. The assessment looks at the customer's situation and circumstances related to all factors contributing to health, safety, well-being, quality of life and the ability to live independently in the community. It includes a review of the customer's environment in the community, as well as the customer's physical, cognitive, psychological, and social well-being.

The comprehensive assessment tool covers 11 domains: customer demographics, functional impairments [Determination of Need (DON) and Mini-Mental State Exam (MMSE)], physical health history and assessment, behavioral health (including spirituality), medications, nutritional screening, caregiver, transportation, environment, financial and legal status. The assessment also includes identification of existing support systems and the need for further evaluation by other disciplines.

The Person-Centered Plan (PCP) that is developed in collaboration with the customer is based upon the assessment. The PCP identifies all services and supports - both formal and informal, the need for additional evaluation(s), customer 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 Home and Community Based Services (HCBS) waiver provided through the Community Care Program (CCP). 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 CCP services are not available or adequate.

If a customer does not meet eligibility requirements, the Operating Agency (OA) sends the customer a written notice that informs the customer why they are not eligible. The notice also includes a statement that if the customer does not agree with this planned action, the customer can appeal the notice. The notice explains how to request an appeal with the appropriate forms enclosed. Services will continue in accordance with the appeal policy. Section F-1 describes the Fair Hearing Process in more detail.

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

☐ **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:

Interims and Temporary Service Increase (TSIs) refers to assessment types that are completed when a customer is at imminent risk of entering a nursing facility.
Interims are completed for new referrals of customers needing immediate waiver services in order to remain independent in the community. TSIs are completed on existing customers who need additional services to remain independent in the community. OA Care Coordinators complete a DON and use the appropriate Service Cost Maximum (SCM) to authorize a level of services based on the current needs of the customer.

The benefit of an Interim/TSI is that due to the imminent risk of nursing home placement, the new or increased level of services are expedited and are required to be implemented within two calendar days. The OA Care Coordinator conducts another reassessment within 15-30 days depending on the status of the customer and whether they were hospitalized at the time the Interim/TSI was authorized. In this way, the State allows additional services for as long as reassessments indicate they are medically necessary.

OA Care Coordinators are required to complete follow-up and thorough assessment(s) within specified timeframes for customers who have had an Interim/TSI assessment. If the Interim/TSI was completed while the customer was in the hospital, the complete assessment must be completed within 15 calendar days. If the Interim/TSI was completed while the customer is residing in the community, the complete assessment must be completed within 30 days. At the time of the complete reassessment, a new DON is completed, and services are established based on service needs identified at that time.

If a request for an Interim/TSI is denied, OA Care Coordinators are required to refer customers to other needed services and supports.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	160164
Year 2	160164
Year 3	160164
Year 4	160164
Year 5	160164

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

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

◉ **Not applicable. The state does not reserve capacity.**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

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

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

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

There are no specific policies related to prioritization of waiver services or assessments. Customers who meet eligibility requirements are enrolled in the waiver upon completion of the waiver assessment. There is no waiting list for services.

For those customers who are enrolled in Managed Care Organizations (MCOs), State-established policies governing the selection of customers for entrance to the waiver remain the same as for all customers. Initial waiver eligibility is to be conducted by the State contracted Care Coordination Units (CCUs), who are the same entities providing care coordination on behalf of the waiver customers not enrolled in an MCO. The CCUs use the same objective criteria for all customers. Selection of entrants does not violate the requirement that otherwise eligible customers have comparable access to all services offered in the waiver.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ○ **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:

Adults age 19 and above without dependent children and with income at or below 138% of the Federal Poverty Level (Adult ACA Population) as provided in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act) and Section 42 CFR 435.119 of the federal regulations.

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

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

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

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

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

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR § 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in section 1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

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

  (*select one*):

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

    Specify:

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

    (*select one*):

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

      Specify percentage:

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

      Specify dollar amount:

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

    Specify percentage:

- (●) **Other standard included under the state plan**

  Specify:

The maintenance allowance for the waiver customer equals the maximum income a customer can have and be eligible under 435.217 group.

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**
Specify:

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

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

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

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

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

  Specify:

- ( ) **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.735:

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:
- ○ **The following dollar amount:**

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

  Specify formula:
- ◉ **Other**

  Specify:

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

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

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

Select one:

- ◉ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

- ○ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

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

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

The CCU is responsible for performing evaluations and reevaluations.

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:

Minimum qualifications for Care Coordinators:

1) Be an R.N, or have a B.S.N, or have a B.A./B.S. degree in social science, social work or related field. One year of program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education up to and including four years of experience replacing a baccalaureate degree; or,

2) Be an LPN with one year of program experience which is defined as assessment of a provision of formal services for the elderly and /or authorizing service provision; or

3) Be waived for persons hired/serving in this capacity prior to December 31, 1991. Provision of a waiver for care coordinators hired prior to December 31, 1991 was based on their years of experience. These care coordinators must maintain certification for a care coordinator and must also follow in-service requirements.

OA Care Coordinators must also complete the following IDoA sponsored training:

1) Preliminary Care Coordination certification training which must occur prior to conducting customer assessments;

2) Care Coordination Certification training and successfully pass the required exam within six months of completing Preliminary training; and

3) Recertification training within each 18-month anniversary of each previous certification.

Care Coordinators must also complete 20 hours of documented in-service training on aging related subjects within each calendar year. Two of those hours are required to be dementia training. For partial years of employment, training is prorated for each full month of employment.

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

The entry point into the waiver, or initial Level of Care (LOC) determination, is through the Universal Screening process which became law on July 1, 1996 (20 ILCS 105/4.03). This law requires all customers seeking admission into a nursing facility on or after July 1, 1996 to be screened to determine the need for nursing facility placement prior to being admitted. This screening is required regardless of income, assets or payment source. The standardized screening tool used for assessment is the Determination of Need (DON). Those customers identified through the screening process as needing nursing facility level of care are afforded the opportunity to select alternate services including supportive living program setting and home and community-based services (HCBS) as long as their needs can be met in those settings.

The necessity for long term care is based on the determined need for a continuum of HCBS services that ultimately prevent inappropriate or premature placement in a nursing facility. The extent and degree of a customer's need for long term care is determined based on consideration of pertinent medical, social and cognitive factors as measured by application of the DON.

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

e. Level of Care Instrument(s). Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of

care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

The CCUs conduct the LOC evaluations and reevaluations utilizing the DON as described above.

The OA utilizes the DON assessment tool to determine level of care eligibility for the Elderly Waiver. The DON measures both ADL and IADL. The DON assesses fifteen areas including eating, bathing, grooming, dressing, transferring, continence, managing money, telephoning, preparing meals, laundry, housework, outside the home, routine health, special health needs and being alone. Any unmet need identified through the completion of the DON is addressed in the customer's PCP.

Additionally, the DON includes the standardized MMSE. The final score is calculated by adding the results of the MMSE, the level of impairment, and the unmet ADL/IADL needs. The minimum threshold for eligibility is a score of 29.

The re-evaluation process does not differ from the evaluation process.

For customers enrolled in a Managed Care Organization, the re-evaluations are conducted by the CCU.

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):*

Care Coordinators enter customer demographic and assessment information into business applications with databases maintained by the OA to ensure the timely reevaluation of customers. These databases contain individual customer level and item level information from the LOC determination tools. Information is collected on a continuous basis. The OA extracts information from these databases regarding the timeliness of the eligibility determinations and redeterminations. The information is summarized in quarterly management reports. The databases also contain checks that ensure that only customers who meet the LOC eligibility threshold are determined eligible for the program.

The OA's business applications generate standard reports to track when annual eligibility determinations are due. These reports also assist the CCUs as a way to track customers and caseloads. Care coordination reports provide Care Coordinators with a reminder of customer assessments due in a given month. The CCU supervisors use standard reports to monitor and evaluate Care Coordinator activities. The reports include current month assessment status, upcoming assessments and case management projections.

The OA and MA monitor timeliness of reevaluations during monitoring activities. Redetermination reports are reviewed with the CCUs during the OA's monthly or quarterly calls.

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

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a +/-5% margin of error. The MA will pull the sample annually.

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

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

The OA requires that CCUs adhere to the OA's standards and policies which require all written and/or electronic documentation related to all evaluations, reevaluations and customer care are maintained for a minimum period of 3 years after the contract terminates under which the customer was served. Active customers' records can never be purged regardless of contract termination dates. CCUs are required to maintain records in a secure, confidential location that is readily accessible during this period.

For customers enrolled in an MCO, the CCU will employ the same maintenance of records procedures.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: Initial Applicant 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 percentage of waiver customers reassessed, as specified in the

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Report: Reassessment of 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:

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

Performance Measures

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

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

Performance Measure:
B3: Number and percent of all LOC determinations and re-evaluations completed using the processes and instruments described in the approved waiver. N: Number of all LOC determinations and re-evaluations completed using the processes and instruments described in the approved waiver. D: Total number of LOC determinations and re-evaluations reviewed.

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

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:

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.

B1: LOC assessment is completed/corrected upon discovery. If eligible, no additional action occurs. If ineligible, billing and claims are adjusted, and the customer receives assistance with accessing other supports and services. Individual staff training occurs as appropriate. Remediation must be completed within 60 days.

B2: LOC reassessment is completed upon discovery. If eligible, no additional correction is required. If ineligible, billing and claims are adjusted and the customer receives assistance with accessing other supports and services. Individual staff training occurs as appropriate. Remediation must be completed within 60 days.

B3: If it is discovered the DON scores do not support the LOC determination, the OA will require a plan of correction from the CCU 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 OA will provide technical assistance or training to individual staff, as appropriate. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

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

Customer choice is a requirement of the Community Care Program (CCP) as established in Illinois Administrative Code 240.330. Upon assessment, a customer has the right to request and, if eligible, to receive waiver services. A customer may choose at any time not to receive services for which eligibility has been determined. Customers are offered the choice between waiver services and institutional care. OA and MCO Care Coordinators discuss service options including institutionalized care and Home and Community Based Waiver services (HCBS) and ensure the customer is fully aware of the pros and cons of each option. The statement regarding choice is on a CCP Participant Consent form which customers verify by signature at the time of assessment that they were offered a choice of HCBS versus institutional care. Freedom of choice is also discussed in the Rights and Responsibilities brochure that is given out to customers at each assessment. Care Coordinators are required to show evidence of the customer's acknowledgement of receipt of the brochure in his/her documentation in the case notes.

Once a customer chooses to have CCP services, the customer is given a choice of provider agency/agencies. Care Coordinators are trained to educate customers and provide information to the customer on the available providers, their settings, if service is to be delivered outside of the home, and to assist customers, if needed, in making an informed choice of providers. The OA utilizes a Participant Consent Form which the customer signs, to document customer preference of providers. If a customer has no preference, then each CCU is required to maintain a provider selection rotation list from which a Care Coordinator will assign a provider to a customer based on the rotation list. When a customer wishes to change providers, a new Consent Form can be completed, and providers will be switched within fifteen days of finalizing the paperwork.

For customers enrolled in an MCO, preference for institutional or HCBS is documented on a Freedom of Choice form provided by the MCO and approved by the MA. The customer must sign the completed form indicating their choice and that they have made an informed decision.

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

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

The State requires that CCUs adhere to the OA's CCP Records Retention, Conversion & Destruction policy regarding standards and policies related to evaluations, reevaluations and customer care documents. Documents are maintained for a minimum period of 3 years after the contract under which the customer was served terminates. Active customer's records can never be purged regardless of contract termination dates. CCUs are required to maintain records in a secure, confidential location that is readily accessible during this period. Records (paper and/or electronic) are kept securely at the local CCUs or at a secure storage facility until they can be purged by the CCU. Electronic data submitted to the OA follows the same maintenance schedule as the paper records. Electronic data stored in the OA's data system and backed up on secure data servers at the State of Illinois's Department of Information Technology (DoIT), are purged in accordance with the OA's CCP Records Retention, Conversion & Destruction policy and upon written notification from the OA to DoIT.

For customers enrolled in an MCO, the plans are required to maintain records for 10 years. MCOs' documentation is stored electronically in their respective secure electronic care management data systems and backed up on secure data servers. MCOs do not store physical documents; these are shredded via HIPAA compliant PHI disposal after they are scanned and uploaded into their care management data systems.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting

Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The Operating Agency (OA) provides access to waiver services to all eligible customers in Illinois including Limited English Proficient (LEP) persons. The OA has translated the six brochures that Care Coordinators are required to provide and explain to customers when completing the comprehensive assessment. The languages are available in Spanish and other prevalent languages as determined by the OA. Required brochure topics include but are not limited to: Bill of Rights, privacy, appeal, available services and supports, Adult Protective Services, etc. In addition, many Care Coordination Units (CCUs) have multi-lingual Care Coordinators to perform assessments with non-English speaking customers.

The OA also requires that Care Coordinators use translators when necessary to complete assessments and provide care coordination services. The OA reimburses the CCUs at a higher rate when a translator is required. The OA also has provider agencies that target specific ethnic populations and therefore have workers who are fluent in specific languages.
This information is provided to the customers during the assessment so the customers can make an informed choice about the provider they choose. Emergency Home Response System (EHRS) provider standards require providers to utilize translation services capable of communicating in 144+ languages. The State has an ongoing collaborative relationship with the Coalition of Limited English-Speaking Elderly (CLESE) to assist the Provider agencies through the provider application process, billing, and payment issues.

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Service**		
Statutory Service	**In-Home Service**		
Other Service	**Automated Medication Dispenser**		
Other Service	**Emergency Home Response 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:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

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

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

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

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

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

Service Definition *(Scope):*

Adult Day Service (ADS) is the direct care and supervision of adults aged 60 or over, in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting. Required service components include:

A balance of purposeful activities to meet the customer's interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical, and spiritual) designed to improve or maintain the optimal functioning of the customer. Activity opportunities shall be available whenever the service provider’s facility is in operation and customers are in attendance. Activity programming shall take into consideration individual differences in age, health status, sensory deficits, lifestyle, ethnicity, religious affiliation, values, experiences, needs, interests and abilities by providing for a variety of types and levels of involvement. ADS providers are required to facilitate monthly Advisory Council meetings in which they solicit input from customers on activities the customers would like to have at the ADS and in the community over the following month. A monthly calendar of activities shall be developed in collaboration with the Advisory Council and posted in a visible place along with notification/discussion of alternative options to daily activities as outlined on the calendar. Additionally, the ADS provider supports customers in pursuing individual interests in community engagement as identified with customers during the person-centered planning process, including pursuit of work and volunteer interests. The ADS provider offers time for rest and relaxation and assists with or supervision of activities of daily living (e.g. walking, eating, toileting, and personal care) based on individual needs identified during the person-centered planning process.

Time for rest and relaxation shall be provided as needed or prescribed.

Provision of health-related services appropriate to the customers’ needs as identified in the provider assessment and/or physician's orders, including health monitoring, nursing intervention on a moderate or intermittent basis for medical conditions and functional limitations, medication monitoring, medication administration or supervision of self-administration, and coordination of health services.

A meal at midday meeting a minimum of one-third of the Dietary Reference Intakes (DRI) as established by the Food and Nutrition Board of the National Academy of Sciences, 10th Revised Edition, 2006, no further amendments or editions included. Supplementary nutritious snacks and special diets shall also be provided as directed by the customer’s physician.

Agency provision or arrangement of transportation, with at least one vehicle physically accessible, to enable customers to receive ADS at the ADS provider's site and participate in sponsored outings. The ADS transportation is billed as a separate service component.

Provision of emergency care as appropriate in accordance with established ADS providers' policies and OA rules.

Services are provided according to the person-centered plan of care within the service cost maximum.

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	Adult Day Service

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Adult Day Service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

89 Ill. Admin. Code 240 Subpart O

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

In-Home Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

In-Home Service (INH) is defined as general, non-medical support by supervised homecare aides who receive specialized training in the provision of INH services. The purpose of providing INH services is to maintain, strengthen, and safeguard functioning of a customer in their own home in accordance with the authorized Person-Centered Plan (PCP).

Services consist of general household activities (for example: meal preparation and routine household care) provided by a trained homecare aide, when the individual is unable to manage the home and care for themself. Homecare aides shall meet such standards of education and training as established by the OA for the provision of these activities.

Specific components of INH shall include the following Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL) functions:
Demonstrating and/or performing meal planning and preparation; routine housekeeping skills/tasks (e.g. making and changing beds, dusting, washing dishes, vacuuming, cleaning floors, cleaning the kitchen and bathroom and laundering the customer's linens and clothing); and simple home maintenance.

Assisting with self-administered medication which shall be limited to:
- Reminding the customer to take their medications;
- Reading instructions for utilization;
- Uncapping medication containers;
- Assisting with measuring vital signs; and,
- Providing the proper liquid and utensil with which to take medications.

Performing/assisting with essential shopping errands may include handling the customer's money (proper accounting to the customer of money handled and provision of receipts are required). These tasks shall be:
- Performed as specifically required by the PCP; and,

- Monitored by the INH supervisor.

Assisting with following a written special diet plan and reinforcement of diet maintenance (can only be provided under the direction of a physician and as required in the PCP).

Observing customers' change in condition and reporting to the supervisor.

Performing/assisting with personal care tasks (e.g. shaving, hair shampooing and combing; bathing and sponge bath, shower bath or tub bath; dressing; brushing and cleaning teeth or dentures and preparation of appropriate cleaning supplies; transferring customer; and assisting customer with range of motion).

Escort to medical facilities, errands, shopping and individual business as specified in the PCP.

INH may include providing transportation to medical facilities, essential errands/shopping, or essential customer business with or on behalf of the customer as specified in the PCP.

Service is limited by the service cost maximum (SCM). There is a process for the provision of temporary service increases (TSI). When a customer is at imminent risk of entering a nursing facility or has been hospitalized for not more than 60 calendar days. Care Coordinators complete a new DON and use the appropriate SCM to authorize a level of services based on the current needs of the customer. Under this TSI process, new or increased level of services are expedited and required to be implemented within two calendar days.

Care Coordinators are required to complete follow-up assessments within specified timeframes for customers who have had a TSI assessment. If the TSI was completed while the customer was in the hospital, the assessment must be completed within 15 calendar days. If the TSI was completed while the customer is residing in the community, the assessment must be completed within 30 days.

The TSI is utilized for customers experiencing short term, acute needs that place them at imminent risk for admission to a nursing facility. Waiver customers can request a reassessment at any point in the year whenever their needs change. As a result, additional service can be provided based on the outcome of the reassessment.

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	Homemaker Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In-Home Service

Provider Category:

Agency

Provider Type:

Homemaker Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

89 Ill Admin Code 240; Subpart O

Homecare aides are required to have a high school or general education diploma, or one year employment in a comparable human services field, or demonstration of continued progress towards meeting the requirements of a general education diploma. Newly-hired home care aides must receive 24 hours of initial pre-service training and are subject to a competency evaluation conducted by the agency. Thereafter, a minimum of 12 hours of annual training is required of which 2 hours must be dementia training.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Automated Medication Dispenser

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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

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

Service Definition *(Scope):*

Automated Medication Dispenser service (AMD) is defined as a portable, mechanical system for individual use that can be programmed to dispense or alert the customer to take non-liquid oral medications in the customer's residence or other temporary residence in Illinois through auditory, visual or voice reminders; to provide tracking and caregiver notification of a missed medication dose; and to provide 24 hour technical assistance to the customer and responsible party for the AMD service in the home. The service may provide additional medication specific directions or prompts to take other medications via other routes such as liquid medications or injections based on individual need.

The purpose of the service is to provide the customer with medication reminders to ensure timely and safe administration of a medication schedule thereby promoting independence and safety of the customers in their own homes as well as potentially reducing the need for nursing home care.

The service is provided by a standalone medication dispenser base unit that is connected to and supported by the Operating Agency (OA) approved AMD provider through either the telephone line or wireless/cellular system. Electronic data on the following information is transmitted and maintained by the provider including, but not limited to missed medication doses, notification of the responsible party when medication doses are missed, power outages or other system defaults are detected and disposition of notifications. The data will be available via electronic reports on an individual basis to the responsible party(ies) and Care Coordinators and in the individual or aggregate to the OA for the oversight of adherence to medication schedules and quality management improvement activities.

Waiver customers are afforded freedom of choice of providers regardless of whether the same AMD provider also provides Emergency Home Response Services. The OA customer agreement form contains a consent form which documents freedom of choice of provider.

The authorization of the service is determined by the Care Coordinator through a screening of the customer’s medication, medical, cognitive and physical needs; potential to benefit; availability of a willing and reliable assisting party(ies) to manage medications; and commitment to use the system appropriately. The service must be authorized in the person-centered plan (PCP).

This service does not include OA or AMD provider medication management, oversight or handling of the customer’s medications. The customer or assisting party must be responsible for managing the acquisition of all prescribed medications, including assuring the medications are administered according to physician orders, and must manually fill the AMD. The customer or assisting party is to work with the AMD provider to program the dispenser initially and to reprogram the dispenser with any changes in the medication schedule. The customer must have an assisting party to act on AMD provider notification of missed medication doses and other system issues such as power outages.
The one-time installation is separate from the monthly rental and service cost. The installation rate covers the following: maintaining adequate local staffing levels of qualified personnel to service necessary administrative activities, installation, and in-home training. The monthly rental and service rate covers the following: maintaining administrative and technical support to program machines, provide 24-hour technical assistance, signal monitoring, troubleshooting, providing machine maintenance and repair requests, sending notifications on missed medication doses and providing reports.

The amount, duration and scope of service is based on the determination of need assessment as conducted by the Care Coordinator, the PCP and the service cost maximum determined by the DON score.

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	Automated Medication Dispenser Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Automated Medication Dispenser

Provider Category:

Agency

Provider Type:

Automated Medication Dispenser Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

As specified in the OA Community Care Program Standards for Automated Medication Dispenser Services–found at 89 Ill. Admin. Code 240 Subpart O.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Emergency Home Response Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Emergency Home Response Service (EHRS) is defined as a 24-hour emergency communication link to an external support center to respond to emergent customer needs. EHRS is provided by a two-way voice communication system consisting of a base unit that can be activated using landline, cellular, and/or internet-based access and a water-resistant activation device worn by the customer that will automatically link the customer to a professionally staffed support center. Whenever the system is engaged by a customer, the support center assesses the situation and directs an appropriate response. EHRS equipment shall include a variety of remote or other specialty activation devices from which the individual can choose in accordance with their specific needs.

Customers utilizing EHRS may choose between a basic EHRS device, an EHRS device with fall detection, and/or a GPS-enabled device with or without fall detection. The purpose of providing EHRS is to improve the independence and safety of customers in their own homes and outside the home in accordance with the authorized Person-Centered Plan (PCP) and thereby help reduce the need for nursing facility care.

Services cover both initial one-time installation and monthly rental costs.

The EHRS service, and any needed adjustment(s) to the service, will be monitored ongoing by care coordinators.

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	Emergency Home Response Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Emergency Home Response Service

Provider Category:

Agency

Provider Type:

Emergency Home Response Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

As specified in the OA's Community Care Program Standards for Emergency Home Response Services found at 89 Ill. Adm. Code 240 Subpart O.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and every three years.

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:

Care Coordination Units (CCUs) contracted by the OA provide care coordination services.

For customers enrolled in a Managed Care Organization (MCO), care coordination is provided by the MCO.

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;

All provider staff are required to have a criminal history and background check completed prior to hire as required by Administrative Code 240.1510.

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

Providers will be required to obtain criminal background checks, check exclusionary list websites and the Adult Protective Services (APS) Registry on each employee as required by Administrative Code 240.1510. No exceptions will be granted. Providers are required to follow Illinois Department of Public Health (IDPH) procedures regarding the Health Care Worker Registry (HCWR), including registering with IDPH and providing/updating an email address where IDPH will send verifications. Agencies are required to utilize the IDPH Web Portal Registry to enter all staff into the HCWR.

(c) the process for ensuring that mandatory investigations have been conducted.

Provider agencies are required to enter the results of all criminal background checks for provider staff into the OA's Training Tracking Portal (TTP). OA staff monitor provider staff files in TTP to ensure all checks have been conducted as part of the compliance review process.

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

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

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

The OA's Adult Protective Services (APS) staff maintain the APS Abuse Registry.

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

All provider staff are required to conduct abuse registry screenings as part of the criminal history and background checks.

(c) the process for ensuring that mandatory screenings have been conducted.

Providers are required to enter the results of all criminal background checks for provider staff into the OA's Training Tracking Portal (TTP). OA staff monitor provider staff files in TTP to ensure all checks have been conducted as part of the compliance review process.

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.*

(a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide.

Legally responsible individuals (LRIs) may provide in-home services (INH) as described in this waiver, as indicated by the customer's comprehensive assessment and person-centered plan (PCP) when the required care is considered extraordinary in nature. An LRI is any person who has a legal duty to provide care for the waiver customer. This includes a customer's spouse, power of attorney (medical, legal, or financial), or representational payee.

(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.

Care Coordinators utilize a comprehensive assessment to identify customers' impairments and unmet needs and create the PCP. If a customer's care is determined to meet the requirements of extraordinary care, an LRI may be authorized.

Extraordinary care refers to:
- care that exceeds what would ordinarily be provided to a person of the same age without a disability or chronic condition, and is necessary to assure the health and welfare of the customer and avoid institutionalization, as documented by the Care Coordination Unit (CCU); or
- care provided by an LRI in instances when the CCU documents there are no other qualified homecare aides available to provide the services required under the customer's PCP; or
- care provided by an LRI in instances when the CCU documents the LRI has a unique ability to meet the needs of the customer, and services provided by the LRI are in the best interest of the customer.

(c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant;

If a customer expresses interest in utilizing an LRI, as a home care aide, and the customer's needs meet the definition of extraordinary care, and is in the best interest of the customer, the CCU must refer the LRI to the customer's chosen In-Home (INH) provider.

The LRI must:
- apply for employment with the INH provider; and
- meet the same eligibility requirements for employment as a non-LRI home care aide; and
- meet the same training requirements as a non-LRI home care aide (which includes 24-hours of pre-service training and 12-hours of annual in-service training); and
- meet the same monitoring requirements as a non-LRI home care aide, including:
  -- background checks (which includes: fingerprint-based criminal background check; Illinois Department of Public Health's Healthcare Worker Registry; US Department of Health and Human Services Office of Inspector General Exclusionary List; Illinois Sex Offender Registry; Illinois Department of Corrections' Sex Offender Search Engine; Illinois Department of Corrections' Inmate Search Engine; Illinois Department of Corrections' Wanted Fugitive Search Engine; Adult Protective Services Abuse Registry; and the National Sex Offender Public Registry); and

  -- use of electronic visit verification (EVV) to ensure payments are made only for services rendered.

(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;

The LRI cannot serve as a customer's authorized representative and may not sign the Client Agreement, Vendor Selection or Eligibility forms, or PCP. The paid relative or legal guardian may not file an appeal on behalf of the customer. The LRI must be able to perform all INH services, including personal care tasks, outlined in the PCP developed by the CCU and the customer.

(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;

Services delivered by an LRI are limited to the specific INH services and hours specified in the PCP. If the INH provider hires the LRI, it must report the approval of the LRI and their relationship to the customer (e.g. spouse, power of attorney (medical, legal, or financial), or representational payee) to the CCU. During the six-month visit conducted by the CCU, the CCU will reaffirm the customer's choice of their LRI and INH provider.

In the event the customer no longer wants the LRI to serve as the homecare aide, the customer may contact the INH provider to request a change in homecare aide or contact the CCU to transfer to a new INH provider.

(f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services;

The INH provider will conduct intensive monitoring/supervision of LRIs including announced and/or unannounced quarterly in-person home visits to ensure the LRI is following the PCP; monthly phone monitoring with the customer during scheduled hours of service; and review of EVV data to ensure the LRI is in the home providing services to the customer during scheduled hours of service. If the supervisor finds any inconsistencies between the PCP and the provision of services, the in-home provider agency will take necessary action.

(g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered.

The Operating Agency (OA) will review the PCP, case notes, EVV data and billing information during monitoring visits of the INH provider to ensure payments are made only for services rendered.

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 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 and legal guardians may provide all in-home care (INH) services as described in this waiver, as indicated by the customer's comprehensive assessment and the development of their Person-Centered Plan (PCP). If a customer expresses interest in utilizing a relative or legal guardian as their home care aide, the Care Coordination Unit (CCU) must refer the relative or legal guardian to the customer's chosen INH provider.

The paid relative or legal guardian must:
- apply for employment with the INH provider; and
- meet the same eligibility requirements as a non-relative/non-legal guardian home care aide (including fingerprint-based criminal background check; Illinois Department of Public Health's Healthcare Worker Registry; US Department of Health and Human Services Office of Inspector General Exclusionary List; Illinois Sex Offender Registry; Illinois Department of Corrections' Sex Offender Search Engine; Illinois Department of Corrections' Inmate Search Engine; Illinois Department of Corrections' Wanted Fugitive Search Engine; Adult Protective Services Abuse Registry; and the National Sex Offender Public Registry); and
- meet the same pre-service and in-service training requirements as a non-relative/non-legal guardian home care aide (which includes: 24-hours of pre-service training and 12-hours of annual in-service training); and
- use electronic visit verification (EVV) to track time spent at the customer's residence and ensure payments are made only for services rendered.

In addition, the INH provider will conduct intensive monitoring/supervision of paid relatives and legal guardians including: announced and/or unannounced quarterly in-person home visits to ensure the paid relative or legal guardian is following the PCP; monthly contact with the customer during scheduled hours of service; quarterly conferences with the paid relatives or legal guardians providing services; and review of EVV data to ensure the paid relative or legal guardian is in the home providing services to the customer during scheduled hours of service. If the supervisor finds any inconsistencies between the PCP and the provision of services, the INH provider will take necessary action. The OA will review the PCP, case notes, EVV data and billing information during monitoring visits of the INH provider to ensure payments are made only for services rendered.

Paid relatives and legal guardians cannot serve as a customer's authorized representative and may not sign the Client Agreement, Vendor Selection or Eligibility forms, Consent Form or PCP. The paid relative or legal guardian may not file an appeal on behalf of the customer. The paid relative or legal guardian must be able to perform all INH services, including personal care tasks, outlined in the PCP developed by the Care Coordination Unit (CCU) Care Coordinator, the customer and authorized representative(s) if any. Services delivered by a paid relative or legal guardian are limited to the specific INH services and hours specified in the PCP. If the INH provider hires the relative or legal guardian, it must report the approval of the relative or legal guardian and their relationship to the customer to the CCU. During the six-month visit conducted by the CCU, the CCU will reaffirm the customer's choice in their paid relative or legal guardian and INH provider.
In the event the customer no longer wants the relative or legal guardian to serve as the homecare aide, the customer may contact the INH provider to request a change in homecare aide or contact the CCU to transfer to a new INH provider.

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

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

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers

have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

The Operating Agency (OA) is compliant with the federal all willing and qualified provider provisions.

The application and the description of the process to become a Community Care Program/Waiver certified provider is outlined on the OA website: https://ilaging.illinois.gov/forprofessionals/procurement.html.

All applications are reviewed by OA procurement staff. There are no restrictions on the application process – The OA reviews all applications to determine compliance with the Waiver and CCP Administrative Rule requirements found at 89 Ill. Admin. Code 240.1600. This link can be found at the OA website located at: https://ilaging.illinois.gov/aboutus/rules-main.html.

Managed Care Organizations (MCO):

MCO Care Coordinators are also required to enable as much choice as possible with the MCOs offering options of providers in order to accommodate customer preferences and choice. MCOs must offer contracts to all willing and qualified OA certified providers in the contracting area that offer HCBS waiver services, as long as the provider adheres to the MCO's quality requirements (Section 5.7.1.2 of MCO contract). To be considered a qualified provider, the provider must be in good standing with the Medicaid Agency's (MA) Fee for Service (FFS) Medical Program. MCOs may establish quality standards in addition to those State and Federal requirements and contract only with providers that meet such standards. Such standards must be approved by the MA, in writing, and MCOs may only terminate the contract of a provider based on failure to meet such standards if two criteria are met a) such standards have been in effect for at minimum one (1) year, and b) providers are informed at the time such standards come into effect. All MCOs provide statewide coverage, with the exception of CountyCare, which covers Cook county, only. County Care must offer contracts to all OA certified providers in Cook county.

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

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Provider Enrollment 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**

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 monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

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

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

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

Performance Measure:
C3: Number and percent of in-home workers who received training in accordance with state requirements and the approved waiver. N: Number of in-home workers who received training in accordance with state requirements and the approved waiver. D: Total number of in-home workers.

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

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:

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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:

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 Operating Agency (OA) conducts a quality improvement review for each Care Coordination Unit (CCU) at least once every three year contract period to ensure compliance with contractual obligations, as specified in Appendix A.

The OA conducts a quality improvement review for each provider at least once every three years. Quality improvement reviews for each provider use a standardized tool to assess compliance with service-specific requirements at 89 Ill. Admin. Code 240 and review of a representative sample of customers to review their PCP, services provided and customer experiences. The customer sample size is based on how many customers are receiving services.

On-site quality improvement reviews are conducted for In-home (INH) and Adult Day Services (ADS) providers. Desk reviews are conducted for Emergency Home Response Service (EHRS) and Automated Medication Dispenser (AMD) providers. Results are discussed with the provider prior to exit and, depending on the nature of the findings, a plan of correction is required by the OA.

After conducting compliance reviews, the OA summarizes information on each performance indicator targeting the following users: the Medicaid Agency (MA), the OA, CCUs, and providers.

The OA maintains results from quality improvement reviews and reports results to the MA as required.

The MA and OA review statewide performance data during quarterly meetings. The summarized data assists the two agencies with identifying potentially problematic trends and tracks the effects of remediation efforts to improve performance. Similarly, detailed reports for each level of entity are shared quarterly. These reports provide the basis for trend identification and specific areas of problems, leading to remediation. When individual problems with existing provider qualifications and contract compliance are identified, there is an initial effort to resolve the situation. The OA may conduct more frequent quality improvement reviews based on a variety of reasons that may be the result of customer/family caregiver complaints, billing issues or a critical event report, among others. Additional reviews may also occur if numerous complaints or event reports are received for the same agency. In the case of problems identified through the grievance system, the OA follows the process outlined in Appendix F-3 of this application. For other types of compliance problems, the State makes an initial request for corrective action. This corrective action request is tracked until there is a successful resolution. If there is not successful resolution, the State may take contract action under 89 Ill. Admin. Code 240.1665. These actions include 1) suspension of new referrals; 2) fines; or 3) contract termination.

Annually, the MA conducts comprehensive focused reviews using a statewide sample of customer records. Person-Centered Plan (PCP) implementation and customer satisfaction are monitored during these reviews. The MA submits findings from routine monitoring to the OA for follow-up and remediation.

The MA conducts routine programmatic and fiscal monitoring for both the OA and the MCOs. The MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the MCOs.

The MA’s sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a +/-5% margin of error. The MA will pull the sample annually.

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

b. Methods for Remediation/Fixing Individual Problems

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

C1: If a new waiver provider fails to meet initial requirements, the MA informs the provider of disposition of application and does not enroll into the Medicaid system. The OA is also notified of findings.

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

C3: The training requirements will be completed. The OA may require a plan of correction from the in-home service provider for how training requirements will continually be met for all in-home staff. Remediation will be completed within 60 calendar days.

C4: If the OA/MCO 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/MCO Care Coordinator will gain the required credentials and/or complete the required training within 60 calendar days.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

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 recieved. *(Specify and describe the types of settings in which waiver services are received.)*

In-Home Services, Automated Medication Dispenser, and Emergency Home Response Services are provided in the customer's home.

Adult Day Services are provided in non-residential settings certified in accordance with 89 Ill. Admin. Code 240.1550 and shall meet the following criteria:

- A location will have a home and community-based setting that allows for services to be provided in the most integrated setting appropriate for each customer without having the effect of isolating any customer from the broader community. (See 42 CFR 441.301(c)(5)(v) and 42 CFR 441.301(c)(4)(i).)

- Such setting will ensure a customer's rights of privacy, dignity and respect and freedom from coercion and restraint; optimize, but not regiment, customer initiative, autonomy, and independence in making life choices, including daily activities, physical environment, and with whom to interact (See 42 CFR 441.301(c)(4)(iv)); and facilitate customer choice regarding services and supports, and who provides them.

- A location is not presumed to be a home and community-based setting if set in a publicly or private-owned facility providing inpatient treatment; on the grounds of, or adjacent to, a public institution; or with the effect of isolating participants from the broader community of individuals not receiving Medicaid Waiver services, as determined by the federal Centers for Medicare and Medicaid Services on a case-by-case basis.

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.)*

The Operating Agency (OA) validates all Adult Day Service (non-residential) provider locations in accordance with 89 Ill. Admin. Code 240.1550 and 42 CFR 441.301(c)(5)(v) and 42 CFR 441.301(c)(4)(i). The OA conducts on site reviews initially and then every 3 years using a Quality Improvement (QI) review tool which includes questions specific to ensuring the setting is a home and community-based setting that allows for services to be provided in the most integrated setting appropriate for each customer without having the effect of isolating any customer from the broader community.

Ongoing oversight includes:

- Every 3 years, the OA pulls a representative sample of customers based on how many customers are receiving services to review their PCP, services provided and customer experiences. Site visits are scheduled and are comprehensive in nature. Results are discussed with the provider prior to exit and, depending on the nature of the findings, a plan of correction is required by the OA. Results from site visits are maintained by the OA and reports results to the Medicaid Agency (MA) as required. The OA and MA discuss issues identified during the visits during the quarterly quality meetings.

- The OA contracts with Care Coordination Units (CCUs) who assess each customer a minimum of twice annually to develop a PCP, ensure the PCP is being implemented and assure the ongoing health, welfare and safety of the waiver customers.

The QI review tool includes an examination of all areas listed in 89 Ill. Admin. Code 240.1550.

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

☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☒ **Facilitates individual choice regarding services and supports, and who provides them.**

☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

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

○ **No, the waiver does not include provider-owned or controlled settings.**

◉ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☐ **Each individual has privacy in their sleeping or living unit:**

☐ **Units have entrance doors lockable by the individual.**

☐ **Only appropriate staff have keys to unit entrance doors.**

☐ **Individuals sharing units have a choice of roommates in that setting.**

☐ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☒ **Individuals have the freedom and support to control their own schedules and activities.**

☒ **Individuals have access to food at any time.**

☒ **Individuals are able to have visitors of their choosing at any time.**

☒ **The setting is physically accessible to the individual.**

☒ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Plan (PCP)

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☒ **Registered nurse, licensed to practice in the state**

☒ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Minimum qualifications for Care Coordinators:

1) Be an R.N, or have a B.S.N, or have a B.A./B.S. degree in social science, social work or related field. One year of program experience, which is defined as assessment, provision, and/or authorization of formal services for older adults, may replace one year of college education up to and including four years of experience replacing a baccalaureate degree; or,

2) Be an LPN with one year of program experience which is defined as assessment of a provision of formal services for older adults and /or authorizing service provision; or

3) Be waived for persons hired/serving in this capacity prior to December 31, 1991. Provision of a waiver for care coordinators hired prior to December 31, 1991 was based on their years of experience. These care coordinators must maintain certification for a case manager and must also follow in-service requirements.

Care Coordinators must also complete the following Operating Agency (OA) sponsored training as specified in 89 Ill. Admin. Code 240.1440:

1) Prior to performing Community Care Program (CCP) eligibility determinations and developing person- centered plans (PCP) of care, each care coordinator and each supervisor acting as a care coordinator shall successfully complete OA sponsored training on the CCP training comprehensive assessment tool, care planning, dementia training, and Choices for Care screening.

2) Successful completion of this training shall be established by certification.

3) Recertification of CCP training must be completed within the 18 months anniversary of each previous certification.

Annual In-Services Training Requirements:

1) Annually, each care coordinator supervisor and care coordinator shall complete 20 hours of documented in-service training on aging related subjects. Two of those hours shall be dementia training which shall include subjects related to Alzheimer's, Dementia and Related Disorders; Safety Risks; and Communication and Behavior.

2) For partial years of employment, training shall be prorated to equal 1.5 hours for each full month of employment. Documented participation in in-house staff training and/or local, State, regional or national conferences on aging related subjects will qualify as in-service training on an hour-for-hour basis. Recertification hours will not qualify for successful completion of this training. Completion of this training shall be established by certification.

For customers enrolled in a Managed Care Organization (MCO), the MCO Care Coordinators are responsible for PCP development. Qualifications for the MCO Care Coordinators may slightly vary within each of the MCOs however, minimally each MCO must meet the qualifications outlined in the OA’s Administrative Rules for Care Coordinators (89 Ill. Admin. Code 220.605). MCO Care Coordinators are assigned based on customer need and identified risk. At minimum, qualifications include the following license or education level:

• Registered Nurse (RN) in Illinois
• Bachelor's degree in nursing, social sciences, social work or related field
• Licensed practical nurse (LPN) with one (1) years’ experience in conducting comprehensive assessments and provision of formal service for the elderly
• One (1) year of satisfactory program experience may replace one year of college education, at least four (4) years of experience replacing baccalaureate degree

The MCO Care Coordinators are required to complete 20 hours of training, initially and annually, as specified in the MCO contract. They are not required to complete the OA sponsored training; however, if they do complete the OA sponsored training, it will be counted toward their total hours of required training.

MCO Care Coordinators must be trained on topics specific to the type of Home and Community-Based Services

(HCBS) waiver customer they are serving. For the Elderly Waiver, training must include Aging related subjects.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

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

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(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 to direct and be actively engaged in the service plan development process;

The OA or MCO Care Coordinator contacts the customer to select a time to meet to develop the Person-Centered Plan (PCP). During this conversation, the time of the actual meeting(s) is scheduled at the convenience of the customer, and/or the customer's representative, and any other parties the customer wishes to have included. The customer is encouraged to include the person(s) of their choosing to attend the in person visit. In person visits are often conducted in the customer's residence, as this is most convenient for the customer. Changes to location are to meet the customers' needs and are not for the convenience of OA/MCO Care Coordinator. Information gathered by the assessment is used in the development of the Person-Centered Plan (PCP).

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

The customer's right to determine who is included in the process is articulated in the OA's "Home Care Participant Bill of Rights" and each MCO's customer rights document. This is given to all customers at the time of assessment and each reassessment. Also, as described in (a) above, for both the OA and MCO Care Coordinators, their routine practice requires that they inquire and document in the PCP the customer's authority to determine who is included in the assessment and person-centered planning process.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The State is committed to implementation of a person-centered planning process as required by 42 CFR 441.301 (c)(4)(5). The OA and MCO Care Coordinators are trained to include the customer in every aspect of assessment and Person-Centered Plan (PCP) development, including providing the customer, their authorized representative(s), any anyone of their choosing with the opportunity to participate in the planning development process. All contact with the customer reflects their cultural considerations and is conducted using accessible information presented in readily understood language.

Within 30 days of the request for services, the CCU must complete the Determination of Need (DON) assessment. The DON evaluates the customer's level of impairment in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and whether the customer's care needs are met by family members or other supports and includes the full Mini-Mental State Exam (MMSE), which measures cognitive function. The DON assesses 15 areas including; eating, bathing, grooming, dressing, transferring, continence, managing money, telephoning, preparing meals, laundry, housework, outside the home, routine health, special health, and being alone. The DON is generally conducted in the customer's residence except for reassessments of Adult Day Service (ADS) customers, which may be conducted at the ADS site. The assessment is scheduled at the convenience of the customer and other parties the customer wishes to have included. Once a customer has been determined to be eligible for waiver services through the DON, the person-centered planning process begins.

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

Once the DON is completed and waiver eligibility is established, the OA or MCO Care Coordinator contacts the customer or their representative to schedule an in person visit. Customers and anyone they wish to include are encouraged to have an active role in the development of the PCP. This visit is generally conducted in the customer's residence as this is most convenient for the customer and enables the OA Care Coordinator to see the customer’s function in their home environment. Reassessments for customers who attend Adult Day Service may, on occasion, take place at the provider’s setting if it is determined an assessment in the home is not an option. Changes to location are to meet the customers’ needs and are not for the convenience of OA Care Coordinator.

The OA and MCO Care Coordinator must complete the comprehensive assessment and PCP within 30 calendar days of request for services, unless the delay is caused by the customer. Reassessments must occur at least annually or within 30 calendar days when the customer experiences a change in needs or requests a reassessment.
If a customer transitions from an MCO to fee-for-service, the OA honors the PCP from the MCO until a new assessment is completed. The assessment and new PCP must be completed within 30 days.

Per the MCO contract, if the customer is newly eligible for waiver services, the PCP must be developed within fifteen (15) days after the MCO is notified that the customer is determined eligible for waiver services. For customers transferring MCOs and for whom a PCP has already been developed, the MCO will use the customer’s existing service plan, and that PCP will remain in effect for at least a ninety (90) day transition period unless changed with the input and consent of the customer and only after completion of a face-to-face assessment. If the customer is fee-for-service (FFS) and receiving waiver services on the date they become eligible for managed care, the MCO will use the customer’s existing FFS PCP and will remain in effect for at least a ninety (90) day transition period unless changed with the input and consent of the customer and only after completion of a face-to-face assessment.

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

The OA and MCO Care Coordinators review the DON to identify the customer's level of impairment in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and whether the customer's care needs are met by family members or other supports. These needs are added to the PCP along with the waiver services or informal supports to meet the unmet needs.

Both OA and MCO Care Coordinators complete a comprehensive assessment. OA and MCO Care Coordinators are trained to engage the customer to direct the PCP planning process as much as possible. These assessments allow customers to articulate their strengths, needs, goals, health status concerns, and desires. Using this as a basis for a holistic approach to care coordination, the assessments allow for evaluation of the customer’s living situation and life circumstances and identifies all factors contributing to quality of life and the customer’s ability to live independently in the community. In addition, the PCP process incorporates the customer’s strengths, capacities, needs, preferences,

desired outcomes, personal goals, risks, and ways to mitigate or eliminate the risk, and it reviews relevant issues, such as housing, recreation, and emotional health. Customers are educated by the OA and MCO Care Coordinators notify them when there is a change in the customer's situation or needs change in-between assessments, so that a new assessment can be conducted and the PCP may be updated.

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

The OA and MCO Care Coordinators discuss with the customer, legal representative, and anyone of their choosing, the array of services available through the waiver and from other funding sources. It is the OA and MCO Care Coordinator's responsibility to explain all service options and informal supports that are available through other state and federal agencies, local entities, and charitable organizations that may assist the customer in meeting their needs and attaining their goals. Customers also sign an acknowledgement form at each assessment verifying service options were explained to them, and they had freedom of choice in choosing their service(s) and their service provider(s).

The PCP that emerges from this conversation reflects that all customers' needs, preferences and goals, and health status issues are addressed through State Plan Medicaid services, waiver services, and informal supports. The customers must sign the PCP acknowledging their agreement with the plan and that it meets their needs identified in the assessment.

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

All customer goals, strengths and barriers/risks in consideration of these goals, needs (including health care needs), and preferences, such as cultural preferences, living arrangements, and provider preferences for language and time of services are gathered in the comprehensive assessment and must be addressed on the PCP. Customer's preferences are obtained throughout the entire assessment process and during the development of the PCP. The PCP includes the type, amount, frequency, and duration of waiver services, and includes services and supports not covered under the waiver, all related to the needs and preferences expressed by the customer.

e) How waiver and other services are coordinated:

It is the responsibility of the OA and MCO Care Coordinator to ensure services are appropriately authorized and coordinated. The copy of the PCP is given to the customer and to each service provider listed on the PCP, so they are aware of all services or assistance in the home and community the customer is receiving. Providers are required to report any changes in the customer situation to the OA or MCO Care Coordinator, including a disruption of services. Identifying all providers in the home on the PCP assists the providers to know who should be in the home, providing an additional level of quality assurance. If the OA or MCO Care Coordinator becomes aware of a non-waiver service being provided in the home or community while waiver services are provided, this will be noted in the PCP.

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

The OA and MCO Care Coordinators provide brochures to customers that outline the rights and responsibilities of the customer, MA, and OA, as it relates to receiving services. Customers sign an acknowledgement that they understand the information shared and agree to follow the requirements. This is completed at the initial assessment and annually at each reassessment.

Following service authorization, the OA and MCO Care Coordinator ensure services have been implemented. If it is discovered a service has not been implemented, or is not being provided according to the PCP, the Care Coordinator will reach out to the customer and/or provider to determine the cause and update the PCP as necessary.
OA Care Coordinators are required to contact the customer every 6 months, either remotely or in person, or provide valid justification in the record for the lack of contact. The MCO Care Coordinators are required to have face-to-face contact with the customer every 90 days or provide valid justification in the record for the lack of contact. The purpose of these visit is to ensure services are being delivered in accordance with the PCP, including the type, amount, frequency, and scope specified in the PCP. If it's determined the services aren't meeting the needs of the customer, the OA or MCO Care Coordinator may revise the PCP by conducting a reassessment or simply making an

adjustment to the PCP.

Waiver service providers are also required to notify the OA or MCO Care Coordinator of changes in the customer's status.

g) How and when the plan is updated, including when the customer's needs changed:

A new assessment is conducted at least annually, or as requested by the customer/authorized representative, and when the customer experiences a change in his or her needs that indicates the need for a reassessment, including following discharge from a hospital or other institutional setting.

Additionally, as mentioned above, customers are educated by the OA and MCO Care Coordinators to notify them when there is a change in the customer's situation or needs change in-between assessments, so a new assessment can be conducted and the PCP may be updated.

(h) how the customer engages in and/or directs the planning process;

Regardless of whether the customer is fee-for-service or managed care, customers and anyone they wish to include are to have an active role in the development of the PCP. 89 Ill Admin. Code 240.550 provides an opportunity for 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 date and time of the in-person visit is collaborated and based on the customer's preference. The in-person 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's function in their home environment. Reassessments for Adult Day Service customers, if necessary, may on occasion take place at the provider setting if it is determined that an assessment in the home is not an option. Changes to location are to meet the customers' needs and are not for the convenience of Care Coordinators.

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

Customers or their legal representative are required to sign the PCP validating their consent and approval. Additionally, customers also sign an acknowledgement form verifying that service options were explained to them, and they had freedom of choice in choosing their service(s) and service provider(s). Customers receive a copy of their PCP at initiation and when updated.

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.

OA and MCO Care Coordinators assess customer needs, evaluate current customer risks and work with the customer to identify the resources and strategies to mitigate these risks through the linkage and delivery of services. For example, customers assessed for risk of falls or elopement are connected with appropriate waiver services such as INH and EHRS. Customers identified as being at nutritional risk may be referred to INH or ADS waiver services or Older Americans Act funded home delivered meals. In addition, for those customers enrolled in a managed care plan, the MCOs use predictive modeling reports and other surveillance data, including claims data to assess risk and identify risk level changes.

The OA and MCO comprehensive assessment tools require the Care Coordinator and customer to discuss other factors or services beyond waiver services that may help mitigate risk. This may include behavioral health services to address depression, anxiety and abuse of alcohol or other substances including illegal substances and medications; caregivers; physical health; mitigation to prevent occurrences and risks of falls are explored and addressed. These are explored and addressed as they may increase and serve as barriers to the customer's ability to live as safely and independently as possible. All risks are identified and discussed while developing the PCP. Through service planning interventions, identified risk(s) are mitigated and barriers are addressed with interventions which are mutually agreed upon by the customer and the OA or MCO Care Coordinator.

Additionally, a backup plan to the PCP is formulated for every customer who lives independently in the community and receives waiver services. The OA or MCO Care Coordinator develops the backup plan and works with the customer to ensure necessary arrangements for backup plans are in place.

The back up plan is specific to the customer's needs and preferences. The back up plan addresses the services currently in place, the urgency for receiving backup services should the current service be interrupted, and specific written instructions for addressing the gap. This includes names and telephone numbers of persons or agencies who are available to immediately assist in a backup arrangement. The list may consist of family, friends, community supports, or provider agencies. OA and MCO Care Coordinators are trained to understand that a sufficient backup plan is not to just rely on calling 911, but rather one that utilizes other formal social service agencies, as well as family, neighbors and friends, and assistive technology devices. Together, the OA or MCO Care Coordinator, customer and anyone else the customer elects to be engaged in the process discuss the availability of both formal and informal options in the event the authorized services in the PCP are not provided and establish a backup plan to meet the customer’s needs. The Care Coordinator sends a copy of the backup plan to the customer so it may be posted in the customer’s home in a location that is accessible and visible to the customer and other providers that support the customer.

Additionally, CCP rule [89 Ill Admin. Code 240.1510], providers are responsible to have a policy for an all-hazards disaster operations plan including but not limited to medical, home or site-related, customer-related, weather-related and vehicle/transportation emergencies.

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 OA enrolls all willing and qualified providers. The OA notifies the CCUs and MCOs of all approved providers in their geographic service areas. Freedom of choice is afforded to all customers in the waiver. Care Coordinators meet with the customers to discuss their goals and preferences when developing the PCP. The OA or MCO Care Coordinator provides information about the service providers available to each customer and to answer any questions that arise. If the customer has no preference of a provider, the OA and MCO Care Coordinators are required to utilize a rotating service provider list. This list includes all service providers in the geographic service area and is maintained at each local CCU and MCO. Customers must sign an acknowledgement form that indicates they were afforded freedom of choice. In order to assist customers in making an informed choice, authorized provider information is available on the OA and MCO websites for customers and their families to review available service providers and service specific details about each provider. Each service provider is also encouraged to have its own brochures and advertising material available upon customer request. Customers and families are encouraged to visit Adult Day Service (ADS) providers before agreeing to services at the ADS.

Additionally, the MCO contract requires that each MCO must have contracts in place with a sufficient number of Providers within each county throughout the State to ensure the Affiliated Providers can serve at least eighty percent (80%) of the number of customers in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) such Providers, so long as such Providers accept Contractor’s rates, even if one (1) served more than eighty percent (80%) of the customers, unless the MA grants Contractor an exception. It is the State’s goal that this will ensure choice on behalf of the waiver customers.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

While the OA and the MCOs have day-to-day responsibility for the completion and implementation of the Person-Centered Plan (PCP), the PCP is subject to oversight from the MA.

This oversight is accomplished through the MA’s Quality Improvement System that uses either a 100% sample or a statistically valid representative sampling methodology, that has a 95% confidence level and a +/-5% margin of error. The MA contracts with a Quality Improvement Organization (QIO) to review the OA/CCUs, and with an External Quality Review Organization (EQRO) to review the MCOs.

The review schedule is determined by the QIO and EQRO. Both perform remote record reviews to assess compliance with the performance measures (PMs), as well as with all applicable state and federal requirements, and MCO contractual requirements. A report of findings is shared with the OA and MCO by individual PM, along with recommendations for remediation of findings and/or needed systemic improvement(s). Timeliness of remediation is reported back to the MA based on the requirements of each PM, including immediately, within thirty (30), sixty (60), or ninety (90) days, or any remaining outstanding remediation. Information related to remote record reviews is also shared during quarterly meetings between the MA and OA.

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:

For customers enrolled in an MCO, the MCO is responsible for maintenance of PCP forms.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, 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 MA is responsible for monitoring the implementation of the Person-Centered Plan (PCP) and responsibile to ensure the customer's health, safety, 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;

The MA contracts with a Quality Improvement Organization (QIO) to perform annual remote record reviews of CCUs statewide and contracts with an External Quality Review Organization (EQRO) to perform annual remote record reviews of each MCO to assess compliance with the performance measures (PMs), as well as with all applicable state and federal requirements, and contractual requirements.

Monitoring activities ensure the PCP addresses all customer goals, needs, and health and safety risk factors identified by the assessment and effectiveness of the backup plan. The customer sample is either 100% or a statistically valid representative sample having a 95% confidence level and a +/- 5% margin of error.

OA Care Coordinators are required to contact the customer remotely or in person every 6 months or provide valid justification in the record for the lack of contact. The MCO Care Coordinators are required to have face-to-face contact with the customer every 90 days or provide valid justification in the record for the lack of contact. The purpose of these contacts are to ensure services are being delivered in accordance with the PCP, including the type, amount, frequency, and scope specified in the PCP. If it's determined the services aren't meeting the needs of the customer, the Care Coordinator may revise the PCP by conducting a reassessment or simply making an adjustment to the PCP.

c) the frequency with which monitoring is performed;

Reviews are conducted annually at the CCUs and quarterly at each MCO. A report of findings is provided to the MA, OA, CCU, and MCO at the conclusion of each record review. The report consists of a summary of findings for each customer record reviewed and a summary of overall findings detailed by performance measure. Remediation activities are tracked to ensure 100% remediation of findings. Timeframes for completion of remediation are reported in thirty (30), sixty (60), ninety (90), or greater than ninety (90) days. Remediation activities are to be consistent with the approved activities detailed within each performance measure. The MA and OA work collaboratively to follow-up with the CCUs and MCOs to ensure remediation occurs within the required timeframes.

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

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

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:

Performance Measure:
D2: Number and percent of OA and MCO customers' PCPs that address all needs identified by the assessment. N: Number of OA and MCO PCPs reviewed that address all needs identified by the assessment. D: Total number of OA and MCO PCPs reviewed.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D3: Number and percent of OA and MCO customers' PCPs that address all health and safety risk factors identified by the assessment. N: Number of OA and MCO PCPs reviewed that address all customer health and safety risk factors identified by the assessment. D: Total number of OA and MCO PCPs reviewed.

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

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:

Performance Measure:
D4: Number and percent of OA and MCO customers who receive in-home service (INH) whose Person Centered Plan (PCP) includes a backup plan. N: Number of OA and MCO customers who receive INH whose PCP includes a backup plan. D: Total OA and MCO customers reviewed.

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

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:

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:
D5: Number and percent of OA customers contacted by their OA Care Coordinator

every 6 months to monitor service provision or gaps in service delivery. N: Number of OA customers contacted by their OA Care Coordinator every 6 months to monitor service provision or gaps in service delivery. D: Total number of OA customers reviewed.

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

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

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

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:

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 and MCO waiver customers who have their PCP updated every 12 months. N: Number of OA and MCO waiver customers who have their PCP updated every 12 months. D: Total number of OA and MCO waiver customers with PCPs due during the period reviewed.

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

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:
D8: Number and percent of OA and MCO waiver customers who received updates to the PCP when there was a change in customer need. N: Number of OA and MCO waiver customers reviewed that received updates to PCP when there was a change in customer need. D: Total number of OA and MCO waiver customers reviewed where a change in need was identified.

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

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:

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 and MCO customers who received services in the type, scope, amount, duration, and frequency as specified in the PCP. N: Number of OA and MCO customers who received services in the type, scope, amount, duration, and frequency as specified in the PCP. D: Total number of OA and MCO customers reviewed.

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

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:

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: Number and percent of OA and MCO records that indicate choice was offered between waiver services and institutional care; and between/among services and providers. N: Number of OA and MCO records reviewed that indicate choice was offered between waiver services and institutional care; and between/among services and providers. D: Total number of OA and MCO records reviewed.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

D4: The CCU/MCO will develop and implement a backup plan and revisions to customer PCP. The CCU/MCO will provide training to Care Coordinators. Remediation must be completed within 30 days.

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

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

D7: If PCPs are untimely, the OA/MA will require completion of overdue PCPs and justification from the care coordinator. The OA/MCO may require a plan of correction for Care Coordinator training. Remediation must be completed within 60 days.

D8: If PCPs are not updated when there is documentation that a customer's needs changed, the OA/MCO will require the CCU/MCO update the PCP. The OA/MCO will require the CCU/MCO correct the PCPs and provide training to the Care Coordinator. Remediation must be completed within 60 days.

D9: If a customer does not receive services as specified in the PCP, the CCU/MCO will determine if a correction or adjustment of the PCP, services authorized, or services vouchered is needed. If not, services will be implemented as authorized. The CCU/MCO may also provide training to the 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 CCU/MCO will ensure choice was provided as shown by the correction of documentation to indicate customer choice. The CCU/MCO may also provide training to Care Coordinators. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

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.

(a) who are not given the choice of home and community-based services as an alternative to the institutional care services; (b) are denied the service(s) or their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated.

Any customer who applies for or receives waiver services has the right to appeal a decision, action or inaction of the Operating Agency (OA), a Care Coordination Unit (CCU), Managed Care Organization (MCO), or a provider. The customer is informed by the CCU or MCO of their right to appeal any action taken regarding services or eligibility This includes the customer's ability to appeal that they were not given the choice of home and community-based services as an alternative to institutional care, the choice of service(s) or the choice of provider(s). Customers also have the ability to appeal when services are denied, suspended, reduced or terminated. In addition, the customer is provided with a Right to Appeal brochure at the time of the initial home visit and upon every reassessment which details the rights to appeal and outlines the appeal process.

Fee-For-Service:

Per 89 Ill. Admin. Code 240.300, Customer Rights and Responsibilities, "The OA will assure that customers receive an explanation of their rights and responsibilities. A copy of the rights and responsibilities shall be provided in written format to all participants during the initial visit for determination of eligibility and upon request by the participant." The same information regarding the requirement to advise customers of appeal rights is repeated in 89 Ill. Admin. Code 240.400 Appeals and Fair Hearings, and in 89 Ill. Admin. Code 240.910 Written Notification.

Customers may file an appeal with the OA and also have the right to request a fair hearing with final decision being made by the Medicaid Agency (MA). Customers may file an appeal by contacting the Senior HelpLine, the CCU (by telephone or in writing) or complete the Notice of Appeal form from the OA's website and mail or e-mail it to the OA. When the OA is advised of the intent to appeal either by letter or by telephone, the OA shall, within 2 business days, send to the customer a Notice of Appeal form to be completed and signed and returned by the customer/authorized representative.

The written notice of appeal must be filed with the OA on the Notice of Appeal form and shall be completed and executed by the customer/authorized representative and returned to the OA. The OA shall send written acknowledgment of receipt to the customer/authorized representative and to all other parties to the appeal, no later than 10 business days after the date of receipt of the Notice of Appeal form.

At each assessment, the Care Coordinator is required to provide and review brochures, including a brochure regarding the customer's right to appeal. Customers receive written notice regarding the outcome of each assessment, which includes information regarding the customer's right to appeal as well as the process to do so.
Per 89 Ill. Admin. Code 240.430, within 60 calendar days after the date of receipt of the Notice of Appeal form, the OA shall conduct an informal review and issue an informal review findings notice that may be delayed pending an extension of time requested by the customer. When the informal hearing is complete, an informal review findings notice with the outcome is issued to the customer, with copies sent to all parties to the appeal. If the appeal is denied, based upon the OA decision resulting from the informal review, the appeal shall automatically proceed to hearing unless the customer/authorized representative withdraws the hearing request in writing. This statement is included on the informal review findings notification sent to the customer/authorized representative. The informal review findings notice includes information on how to request a Fair Hearing.

MCO:

If a customer enrolled in an MCO is appealing their waiver eligibility, the appeal will go through the OA's appeal process as explained above since the OA's CCUs determine eligibility into the waiver. If the customer is appealing the level of services being provided, the appeal will proceed through the MCO's appeal process since the MCO Care Coordinators are developing the Person-Centered Plan (PCP) and authorizing services. Customers enrolled in an MCO may file an internal appeal with the MCO and also have the right to request a fair hearing with final decision being made by the MA. The MA's fair hearings process is the same for all customers, including those enrolled with MCOs. The MA is the final level of appeal. MCOs are required to have a formally structured appeal system that complies with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. 438 to handle all appeals subject to the provisions of such sections of the Act and C.F.R. (including, without limitation, procedures to ensure expedited decision making when a customer's health so necessitates). The MA reviews/approves the MCO's Appeal process guidelines, in compliance with MCO Contract.

The MCO informs customers about the MA's fair hearing process in the customer handbook distributed at the time of enrollment. Information about the fair hearing process is also published on each MCO's website. Appeal information is also provided whenever a customer requests it. A customer may appoint a guardian, caretaker, relative, or provider to represent the customer throughout the appeal process. The MCO shall provide a form and instructions on how the customer may appoint a

representative.

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

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

Each MCO submits a quarterly Grievance and Appeals summary report to the MA. The format of each report is dictated by the MA. The quarterly summary report of Grievances and Appeals filed by customers is organized by categories of medical necessity reviews, access to care, quality of care, transportation, pharmacy, LTSS services and other issues. It includes the total grievance and appeals per 1,000 customers. Additionally, it includes a summary count of any such appeals received during the reporting period including those that go through fair hearings.

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

The State ensures MCO customers are informed by the MCO about their Fair Hearing Process by approving the Customer Handbook, Notice of Adverse Determination, and any Notices of Appeal Resolution letters which must contain the customers' rights to a Fair Hearing and how to request such. The State's External Quality Review Organization (EQRO) also reviews such documents through a desk review and determines if the MCO is compliant during on-site visits. The State reviews/approves the MCO's appeal process guidelines.
The MCOs inform the customer about their right to appeal and their right to a fair hearing both verbally and in writing at the initial visit with the customer, annually, and as needed or requested by the customer. Customers may appeal if services are denied, reduced, suspended, or terminated. In addition, appeals may be made any time the MCO takes an action to deny the service(s) of the customer's choice or the provider(s) of their choice. The appeal process is described in writing in the MCO's Customer Handbook which is reviewed with the customer by the MCO's Care Coordinator.

When services are denied, reduced, suspended, or terminated, or choice is denied, the customer is informed via a Notice of Adverse Determination. This notice includes (a) A statement of what action the MCO intends to take; (b) The reasons for the intended action; and (c) The guidelines or criteria used in making the decision. The Notice of Adverse Determination also contains information on appealing the determination and how services can continue during the period while the customer's appeal is under consideration. The customer is also informed of the right to request, free of cost, access to all copies of relevant information.
The MCOs have a separate appeal process that occurs prior to the Fair Hearing process. If an appeal is upheld by the MCO, the MCO sends a Notice of Appeal Resolution letter. This letter contains instructions/information on the Fair Hearing process.

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

CONTINUED IN MAIN B OPTIONAL:

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution

process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

• **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Do not complete this item.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

For Fee-for-Service (FFS) customers, the Operating Agency (OA) operates the grievance and complaint system.

For customers enrolled in a Managed Care Organization (MCO), the MCOs establish and maintain procedures for reviewing grievances registered by customers.

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

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

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

A customer may file a grievance for any action or inaction taken by a provider or state staff person. Grievances may include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the customer's rights regardless of whether remedial action is requested.Grievance includes a customer's right to dispute an extension of time proposed by the Operating Agency (OA), Care Coordination Unit (CCU), Managed Care Organization (MCO) and/or a provider to make an authorization decision.This includes a grievance related to the OA's, CCU's, MCO's, or a provider's performance of planning, developing, implementing and reviewing the person-centered plan of care, home and community-based settings, settings that are not home and community-based, home and community-based settings compliance and transition.

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

The OA encourages the customer or authorized representative to communicate with the provider, CCU, MCO, or other party to first attempt to resolve the concern, as outlined in the Rights and Responsibilities brochure, before submitting as a grievance.

Customers are informed about their right to file a grievance and the grievance process at initial and each subsequent assessment using the "Participant Bill of Rights". Providers receive a standardized notice outlining the grievance process and provider expectations as they are enrolled/contracted into the program.

A grievance may be filed at any time, either orally or in writing, by the customer or their authorized representative. If the customer indicates they want an authorized representative to file or manage the grievance on their behalf, the party receiving the grievance will document the customer's desire for an authorized representative. The OA shall provide a form and instructions on how the customer may appoint a representative.

The OA can provide assistance to a customer in filing a grievance if requested. The OA's Senior HelpLine (SHL) staff will assist a customer with filing a grievance when the customer contacts the SHL. For customers who need language services (written or oral interpretation) the OA's SHL will provide TTY, auxiliary aids (CART, ASL captioning, tactile interpretation, braille, etc.) and translation services.

For fee-for-service customers, the OA will send the customer 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 the OA will send written notification within 2 calendar days of the decision to extend the timeframe. When a resolution is determined, the customer will be notified of the decision in writing.

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

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

The OA's grievance process is documented in the "Participant Bill of Rights". The customer is informed that filing a grievance or making a complaint is not a prerequisite or substitute for an appeal. Appeals are filed by the customer as outlined in Appendix F-1 of this application. The policies and procedures are compliant with 42 CFR 441.301(c)(7) and ensure the following:

• No punitive or retaliatory action is taken against a customer or an authorized representative for filing a grievance.
• The 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 (including

through the use of audio or video technology) 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.

OA staff receiving the grievance will acknowledge the report was received within 5 business days of the receipt of the report in writing.

Grievances must be resolved within 90 calendar days from the date the OA receives the grievance.

Grievances may be resolved by the SHL, in which case they would be the “assigned staff” for the steps in the grievance process. Assigned staff will determine a resolution upon consultation with lead staff and supervisor and may involve the Homecare Ombudsman. Assigned staff will work with all parties to resolve the issue.
If it appears more than 90 calendar days is needed to resolve a grievance and it is in the best interest of the customer or the customer requested an extension, the OA will alert the customer of the need for an extension. There may be up to a 14-calendar day extension to resolve the grievance. Prior to the 90-calendar day deadline, and within 2 business days of determining the need for an extension, the assigned staff will complete and send written communication of the extension with a summary of the complaint, reason for delay that is in the customer’s best interest, and new deadline to the customer.

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

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

For customers enrolled in an MCO, grievances and complaints are handled through the MCO. A customer may submit his or her grievance orally or in writing, using any method of communication they prefer. An explanation of how to file a grievance is included in all customer handbooks. Examples of grievances include complaints about a provider (a provider or staff member did not respect his/her rights), trouble getting an appointment with his/her provider in an appropriate amount of time, or the customer was unhappy with the quality of care of services he/she received. Customers can also file a grievance if an MCO staff person was rude or insensitive about the customer’s cultural needs or other special needs. At any time during the grievance process, the customer can have someone represent or act on the customer’s behalf. The MCO must acknowledge the receipt of the grievance within 48 hours. The MCO has no longer than 90 days to resolve the grievance; the MCO may inform the customer of their decision verbally or in writing.

The MCO must have a Grievance Committee to review grievances registered by its customers and MCO customers must be represented on the Grievance and Appeal Committee.
At a minimum, the following elements must be included in the Grievance process:

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

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

• The Grievance Committee must have at least one (1) customer on the Committee. The Medicaid Agency (MA) may require that one (1) member of the Grievance Committee be a representative of the MA;

• A summary of all Grievances heard by the Grievance Committee and by independent external reviewers and the responses and disposition of those matters must be submitted to the MA quarterly; and

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Operating Agency (OA) has two network-wide reporting structures for tracking and following up on critical incidents. The first structure covers alleged instances of abuse, neglect, self-neglect, or exploitation (ANE) that are reported to the State's Adult Protective Services (APS) entity. The second reporting structure is the Critical Event Reporting Application (CERA), which includes other critical incidents including those resulting in death or injury—not related to ANE. The APS system applies to both the Fee-for-Service and Managed Care Organization (MCO) populations. The CERA system applies only to the Fee-for-Service population. The MCOs have their own systems for reporting and follow-up on critical and non-critical incidents. The systems are described below.

The types of incidents required to be reported include Critical Incidents, Critical Incidents (Abuse, Neglect, Exploitation), Service Improvement Program (SIP) Complaints, and Request for Change of Status.

Critical Incidents include Anticipated Death, Criminal Act/Participant Alleged Perpetrator/Law Enforcement, Criminal Act/Participant Victim/Law Enforcement, Emergency Department Visit, Fall with Injury, Fall without Injury, Medication Error, Missing Person, Nursing Facility Placement, Property Damage, Restrictive Intervention, Serious Injury, Special Circumstance, Unanticipated/Unexplained Death, and Unanticipated Hospitalization.

Critical Incidents (Abuse, Neglect, Exploitation) include Abandonment, Abuse, Confinement, Financial Exploitation (Theft), Neglect, Passive Neglect, Physical Abuse, Psychological/Emotional Abuse, Restraint, Self-Neglect, Sexual Abuse, and Willful Deprivation.

APS reporting structure for tracking and follow up on critical incidents:

The Adult Protective Services Act (320 ILCS 20/ et seq.) authorizes the OA 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 35 agencies located throughout the state and designated by the Area Agencies on Aging (AAA) and the OA. Many of the APS agencies are also Care Coordination Units (CCUs); however, the APS and CCU contracts are separate. APS agencies conduct investigations and work with adults aged 60 or older (including those covered by the waiver) and adults aged 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 OA 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 State 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 in 320 ILCS 20/2 and at 89 IL Adm. Code 270.210.

The Illinois Adult Protective Services Act (320 ILCS 20/1) requires personnel of the OA's AAAs and providers to be mandated reporters in cases where the adult is unable to self-report. The OA policy specifically states that if a direct service worker witnesses or identifies a case of possible abuse, neglect, self-neglect, or financial exploitation, they are mandated to personally report the allegations to the designated APS agency or to the OA's Hotline number within 24 hours. State regulations covering APS mandated reporters and timelines for reporting are contained in 89 IL Admin. Code 270.230. More information and brochures regarding Older Adult Maltreatment Reporting may be found at: https://ilaging.illinois.gov/protectionadvocacy/abuse.html

Follow-up Actions by the OA can be found at: 89 IL Admin. Code 270.240 Intake of ANE or Self-Neglect Reports Rules may be accessed at the OA's website at: https://ilaging.illinois.gov/protectionadvocacy/abuse.html

The Critical Event Reporting Application (CERA) reporting structure for tracking and follow up on critical incidents:

The CERA is a centralized web-based application used to house event reporting forms, assign work, and track follow-up by primary case management entities, the Care Coordination Units (CCUs). CERA access has been granted to and is required of all providers who serve Fee-for-Service customers under the waiver. All providers are required to use the CERA system for event reporting when they are first notified (learn) of a reportable event. After any initial event report is entered, the corresponding Care Coordinator's dashboard (working queue) is populated for follow-up. The CERA

provides system updates in real-time to all waiver providers involved in the care of the customer for which a report was made.

The CERA Critical Event Reporting policy defines reportable events, follow-up (response) timeframes and procedures specific to event report closure. The Event Reporting policy requires the CCUs and provider network at-large to report and review critical events in a timely manner, actively attempt to mitigate risk(s) associated with their occurrence while implementing risk-mitigation strategies aimed at reducing future critical events.

To further ensure consistent understanding of reportable event definitions, the Critical Event Report policy breaks non-ANE “critical events” into three main categories for which reports are mandatory. The first main category of reportable event is Critical Incidents. Initial reports for critical incidents must be entered into CERA within 7 calendar days of notification. The CCU must establish phone contact with the customer or emergency contact within 15 calendar days of notification.

The second main category of reportable events is the Service Improvement Program (SIP) complaint. SIPs are specific to situations when a customer experiences delayed service start or inability to access waiver services. SIP complaints must be entered within 7 calendar days of being notified of issues with services starting or access to obtain services. The CCU must establish phone contact with the customer or emergency contact within 7 calendar days of notification.

The third and final category of reportable events is Request for Change of Status. A Request for Change of Status occurs when the condition of the customer changes or there is a change in circumstances which affects the ability of the family and/or caregiver to safely provide support and assistance. Initial reports for Change of Status must be entered into CERA within 7 calendar days of notification. The CCU must establish phone contact with the customer or emergency contact within 7 calendar days of notification to determine if an in-person redetermination is necessary.

MCO:

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

Examples of critical events may include but are not limited to:
• Death
• Falls
• Serious physical injury or abuse
• Hospital admission
• Misuse of funds
• Medication error
• Unauthorized use of restraint, seclusion or restrictive physical or chemical restraints
• Elopement or missing person
• Fires
• Possession of firearms (customer or staff)
• Criminal victimization
• Financial exploitation
• Suicide or attempted suicide

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

All incidents will be reported to the compliance officer or designee and entered in the MCOs CI report database. Based on situation, the customer’s age and placement reports will also be made to the appropriate State of Illinois investigative agencies.

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 provided information from the Care Coordination Unit (CCU) at the time of the initial assessment and annual reassessment on abuse, neglect, self-neglect, and exploitation (ANE) and how to report other critical incidents. Training also covers the occurrence of assigned caregiver/workers not showing up for service delivery. The State requires the Care Coordinator to address with customers issues of privacy, safety, and respect during administration of the State's Quality Assurance survey. These questions occur during the assessment/reassessment process and are specific to Care Coordination, as well as each of the 4 core waiver services - Adult Day Service (ADS), In-Home Services (INH), Emergency Home Response Services (EHRS) and Automated Medication Dispenser (AMD).

The need for public awareness has been addressed through campaigns, such as "Break the Silence" and "Engage to Change". These public awareness campaigns, facilitated through Adult Protective Services, provide information and training about how to prevent, recognize, and report situations involving abuse, neglect, self-neglect, and exploitation of all adults.

The Operating Agency (OA) developed a brochure that is provided to all waiver customers and family members/guardians (as applicable) that explains how to report ANE. The OA consent form includes documentation from the customer that they received a copy of the brochure. APS reporting information is also provided on the Individual Back-up Plan, which lists the customer's other emergency information as well.

Care Coordinators receive training as part of the OA required training for all Care Coordinators on critical incident reporting and follow-up. Direct care staff are provided training through their employer and new state provider standards have enhanced requirements for staff training about abuse, neglect, self-neglect, exploitation, and mandated reporting requirements.

MCO:

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

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

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

The Adult Protective Service (APS) and the Critical Events Reporting Application (CERA) systems are responsible for initial intake of referrals and to notify the Operating Agency (OA), the Care Coordination Unit (CCU) and the Care Coordinator of incidents. Depending on the nature of the incident of Abuse and Neglect, Self-Neglect, and Exploitation (ANE), the customer and/or family members, and providers may be notified. The OA has set criteria regarding when notifications are mandatory or when notifications are at the discretion of the Care Coordinator.

The OA has established classifications for critical incidents (i.e., Priority I, II, III,) depending upon the nature and urgency of the event. This classification determines whether an investigation needs to occur in the timeframe for conducting that investigation. The definitions and time frames of these levels are located at 89 IL Admin. Code 270.240.

Timeframes for responding to reports received through CERA.

For Critical Incidents that are APS, a referral to APS for intake must be made within twenty-four (24) hours of learning of the actual or suspected instance of ANE. Referral must be made by calling the 24 Hour APS Hotline or the appropriate APS provider agency. CCUs must complete a case note confirming referral to APS in the customer's case file at the reporter's agency setting (CCU or CCP provider). See below for timeframes for APS response to reports.

For Critical Incidents, the provider must submit an initial event report in CERA within 7 calendar days from the notification date. The CCU must successfully complete phone contact with the customer or their emergency contact person within 15 calendar days from the notification date. A risk mitigation plan must be implemented by the CCU and documented on the event report "60-Day Review Summary" within 60 calendar days of the notification date.

For Service Improvement Program (SIP) complaints, the provider must submit an initial event report in CERA within 7 calendar days from the notification date. The CCU must successfully complete phone contact with the customer or their emergency contact person within 7 calendar days from the notification date. A risk mitigation plan must be implemented by the CCU and documented on the event report "60-Day Review Summary" within 60 calendar days of the notification date.

For a Request for Change of Status, the provider must submit an initial event report in CERA within 7 calendar days from the notification date. The CCU must successfully complete phone contact with the customer or their emergency contact person within 7 calendar days from the notification date to determine if an in-person redetermination is necessary. A risk mitigation plan must be implemented by the CCU and documented on the event report "60-Day Review Summary" within 60 calendar days of the notification date.

Timeframe for responding to reports received through APS.

All actual and alleged instances of ANE shall be reported directly to APS for intake, follow-up and investigation. All cases are entered into the APS Case Management Portal where the status of any investigation and follow up actions are tracked. The OA requires that all reports are investigated with initial contact based on assigned priority. Depending on the nature and seriousness of the allegations, a trained APS caseworker makes a face-to-face contact with the alleged victim with the following time frames:

•Priority One – Reports of abuse or neglect where the alleged victim is reported to be in imminent danger of death or serious physical harm. The caseworker must make a face-to-face visit within 24 hours of the receipt of the report.

•Priority Two – Reports that an alleged victim is being abused, neglected, or financially exploited and the report taker has reason to believe the health and safety consequences to the alleged victim are less serious than priority one reports. The caseworker must make a face-to-face visit within 72 hours of the receipt of the report.

•Priority Three – Reports that an alleged victim is being emotionally abused or the alleged victim's financial resources are being misused or withheld and the report taker has reason to believe there is no immediate or serious threat of harm to the alleged victim. The caseworker must make a face-to-face visit within 7 calendar days of the receipt of the report.

APS investigates all reports and with customer consent, will put interventions in place to address the health, safety, and welfare of the alleged victim. The State's Office of Adult Protective Services' regulations also require certain response timelines by the ANE agency.

The Adult Protective Services Provider Agency (APSPA) shall notify the appropriate CCU or Managed Care Organization (MCO) of all substantiation decisions, regardless of outcome (including “No ANE Substantiated”), made regarding a case of ANE. The APSPA shall provide the CCU or MCO with an electronic copy of the “Report of Substantiation Decision” via the APS Case Management Portal within 2 business days from the date of substantiation.

The CCU is responsible for ensuring the health and welfare of the customer and may authorize additional services, such as intensive care coordination, to protect the welfare of the customer. Critical incidents may also result in a review of customer needs to determine whether a change in the service or level of service is needed.

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

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

The customer who is the subject of a report to APS or customer's family member, or legal representative is informed about the results of the investigation within 30-45 calendar days of the date the report is received. When the APS authority provides the MCO with a complete report of substantiation decision, the MCO has two different requirements regarding contacting the customer. These requirements are directly linked to the outcome of the APS investigation. The first is a 30-calendar day requirement implemented when APS substantiates a report and the customer consents to APS services. The other is a 5-calendar day requirement implemented when the customer refuses the APS investigation at the start or refuses to continue with APS after substantiation.

All substantiation decisions are communicated verbally to the customer during a face-to-face visit. Prior to a substantiation decision, the APS supervisor meets with the APS caseworker to discuss and then signs off on the decision. All APS records are subject to the confidentiality of the APS Act or another act that has stronger requirements.

Notification is documented in the customer’s case record. The APS Program supervisor signs off on the record entry. Compliance with this requirement is reviewed annually as a measurement of case quality. When a case is not substantiated, the customer or (customer’s family member, or legal representative) is informed by the most appropriate method to assure the customer’s confidentiality. For cases that are substantiated, the same confidentiality considerations are applied but notice of the investigation results is most generally incorporated in the face-to-face visit with the customer when a substantiated risk assessment is completed and a case plan is discussed with the customer that focuses on interventions to mitigate risk.

The APS Report of Substantiation Process policy requires the APSPA to directly notify the Care Coordination Unit or the MCO of all substantiation decisions within two business days from the date of substantiation. Additionally, the APSPA is required to notify the MCO of the report of the substantiation decision via email within two business days from the date of substantiation.

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 Operating Agency (OA) oversees the reporting and response of all critical incidents and complaints. The OA uses the Critical Events Reporting Application (CERA) system to analyze trends and to ensure follow up has occurred. For some individual circumstances, the OA may be working with Adult Protective Services Provider Agency (APSPA) or the Care Coordination Unit (CCU) to resolve the issue. The OA's Office of Adult Protective Services maintains a tracking system of Abuse, Neglect, Self-neglect and exploitation (ANE) investigations and statistical reports are generated annually.

Data is used to inform the OA and Medicaid Agency (MA) to monitor system performance and remediate problems. CCUs and Care Coordinators receive information in their quarterly performance reports about critical events involving waiver customers for whom they are responsible. The OA and the CCUs also review statewide and regional performance at quarterly meetings.

For customers enrolled in a Managed Care Organization (MCO), the MCOs maintain an internal reporting system for tracking reports and responses to critical incidents. This system is used for analysis of events to determine whether individual or systemic changes are needed. Critical incident reporting is included in the reporting requirements to the MA. The MA monitors both compliance of performance measures and timeliness of remediation for those waiver customers enrolled in an MCO. Customers in MCOs are included in the representative sampling.

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of restraints**

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

The Operating Agency (OA) and Managed Care Organizations (MCOs) are responsible for detecting the unauthorized use of restraint.

OA oversight includes:

1. Care Coordination Unit (CCU) and Care Coordinator reviews of all Event Reports involving the unauthorized use of restraint.

2. The OA will review instances of the unauthorized use of restraint reported through event reports that are outside the restraint and seclusion policy.

3. During Quality Improvement reviews, the OA will review substantiated instances of the unauthorized use of restraints.

4. Homecare aides and Adult Day Services staff are required to be trained on the use of seclusion and restraints as part of the initial pre-service training.

For customers enrolled in managed care, the MCOs are responsible for detecting the unauthorized use of restraint. Events involving the unauthorized use of restraints are reported to the MCO as a reportable incident and reported to the investigating authority as indicated.

The MCOs and OA are to detect unauthorized use of restraints through face-to-face visits, routine contacts with the customers, and through complaint or incident reporting. The Case Managers are responsible for overseeing the waiver customers and assuring their health, safety, and welfare.

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

and G-2-a-ii.

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

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

Appendix G: Participant Safeguards

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

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

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

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

The OA and MCOs are responsible for detecting the unauthorized use of restrictive interventions. OA oversight includes:

1. CCU and Care Coordinator reviews of all Event Reports involving the unauthorized use of restrictive interventions.

2. The OA will review instances of the unauthorized use of restrictive interventions reported through event reports that are outside the restraint and seclusion policy.

3. During Quality Improvement reviews, the OA will review substantiated instances of the unauthorized use of restrictive interventions.

For customers enrolled in managed care, the MCOs are responsible for detecting the unauthorized use of restrictive interventions. Events involving the unauthorized use of restrictive interventions are reported to the MCO as a reportable incident and reported to the investigating authority as indicated.

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

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

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including

restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

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

Appendix G: Participant Safeguards

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

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

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

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

The OA and MCOs are responsible for detecting the unauthorized use of seclusion. OA oversight includes:

1. CCU and Care Coordinator reviews of all Event Reports involving the unauthorized use of seclusion.

2. The OA will review instances of the unauthorized use of seclusion reported through CERA event reports that are outside the restraint and seclusion policy.

3. During Quality Improvement reviews, the OA will review substantiated instances of the unauthorized use seclusion.

4. Homecare aides and Adult Day Services staff are required to be trained on the use of seclusion and restraints as part of the initial pre-service training.

For customers enrolled in an MCO, the MCOs are responsible for detecting the unauthorized use of seclusion. Events involving the unauthorized use of seclusion are reported to the MCO as a reportable incident and reported to the investigating authority as indicated.

The MCOs and OA are to detect the unauthorized use of seclusion through face-to-face visits, routine contacts with the customers, and through complaint or incident reporting. The Case Managers are responsible for overseeing the waiver customers and assuring their health, safety, and welfare.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

- **Medication Management and Follow-Up**

Do not complete this section

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who**

cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- **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).

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's

methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

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: # and % of records reviewed where the customer/representative (rep) received info from the OA/MCO about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. N: # of records reviewed where the customer/rep received info from the OA/MCO about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. D: Total # of records reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 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: Number and percent of unexplained deaths and substantiated incidents of A/N/E reported to the OA and MCO where appropriate actions were taken to address incident. N: Number of unexplained deaths and substantiated incidents of A/N/E reported to the OA and MCO where appropriate actions were taken to address incident. D: Number of unexplained deaths and substantiated cases of A/N/E.

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

OA and MCO Reports

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G3: Number and percent of deaths related to a substantiated case of abuse or neglect that were reported to the OA and MCO where appropriate actions were taken to address incident. N: Number of deaths related to a substantiated case of abuse or neglect that were reported to the OA and MCO where appropriate actions were taken to address incident. D: Number of substantiated cases resulting in death.

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

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 and MCO Reports

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
G5: Number and percent of APS substantiated incidents of confinement (restraint or seclusion [R&S]) reported to the OA and MCO where appropriate actions were taken to address the incident. N: Number of substantiated incidents of confinement (R/S) reported to the OA and MCO where appropriate actions were taken to address the incident. D: Number of substantiated incidents of confinement (R/S).

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G6: Number and percent of in-home service (INH) and Adult Day Service (ADS) staff who received training on alternative practices to restrictive interventions, including restraint and seclusion (R&S). N: Number of INH and ADS staff who received training on alternative practices to restrictive interventions, including R&S. D: Total number of INH and ADS staff.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Training and Tracking System

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
G7: Number and percent of customer survey respondents who reported to the OA and MCO of being treated well by direct support staff. N: Number of customer survey respondents who reported to the OA and MCO of being treated well by direct support staff. D: Total number of OA and MCO customer survey respondents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA and MCO Customer Satisfaction survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: MCO: CAHPS sampling methodology. OA: Random sample from each Care Coordination Unit (CCU).
	☐ **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:
G8: Number and percent of customers reporting they visited a doctor or practitioner for an annual screening within the last 12 months. N: Number of customers reporting they visited a doctor or practitioner for an annual screening within the last 12 months. D: Total number of customer records reviewed.

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

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

		95% 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 Operating Agency (OA) has a three-prong approach to address health, safety and welfare issues.

First, the state obtains a direct report of potential issues affecting health and safety from the customers. The Care Coordinator completes an initial and annual assessment to determine needs of the customer and uses this information to develop a person-centered plan (PCP). This process includes using the Determination of Need (DON) to identify unmet needs and the assessment to identify customer satisfaction. Some questions on the comprehensive assessment pertain to the customer's perceptions of safety, privacy, and respectful treatment. The Care Coordinator addresses problems identified during the assessment process either as a service planning issue or a Critical Event Reporting Application (CERA) event report. The OA tracks information from the assessment and event reports through its Electronic Community Care Program Information System (eCCPIS) and CERA system. Care Coordinators are required to follow up with any customers reporting they did not feel safe, their privacy is not respected, or they are not treated with respect. Care Coordinators' supervisors monitor the Care Coordinators' performance in these areas. The OA also monitors the performance of the CCUs.

Second, the OA's approach screens out potential workers with criminal backgrounds who seek employment with providers. Provider staff, in addition to meeting educational and training requirements for a job, must undergo a background check as part of the conditions of employment. Providers are responsible for completing the background check, maintain information in the employee file, and enter verification in the training tracking database. The Medicaid Agency (MA) audits for compliance with this requirement when completing quarterly management reports, during the provider audit, and the documentation is verified during the onsite reviews.

Finally, the approach maintains a system to intervene and remediate reported incidents and complaints. The MA maintains the CERA system to deal with critical incidents or complaints involving waiver customers. A critical incident includes a range of defined events that may negatively impact the health and welfare of a waiver customer. These events are classified within one of four levels of intensity, depending on the nature of the incident and the level of risk posed. A complaint includes any oral or written communication by the customer or other interested party expressing dissatisfaction with the operation or provision of service, service quality, service staff, or a failure to provide/offer services.

Any person can report a critical incident or make a complaint by contacting the state's Senior HelpLine, a Care Coordination Unit (CCU), or a provider. The OA uses the CERA system to record information. The Senior HelpLine can enter data. After an incident/Event is reported, the CCU receives notice and is responsible to review each incident or complaint. If the report includes suspected abuse, neglect, or exploitation, the state's Adult Protective Service (APS) agency is immediately notified so caseworkers may begin its investigation as required by Adult Protective Services regulations.

The OA has developed a protocol to process reports of critical incidents and complaints. The protocol defines timelines, notification requirements, referrals, and follow up steps. All critical incidents and complaints must be resolved within OA set timelines, unless there are documented circumstances that preclude a resolution within this timeline. If resolution is not immediately forthcoming, the CCU is responsible for ensuring the health and welfare of the individual during this time.

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 Operating Agency (OA)/Managed Care Organization (MCO) will assure customers know how to report abuse, neglect or exploitation. This will be demonstrated by collection of case work documentation reflecting customers' awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.

G2: The OA/MCO will follow up all outstanding Adult Protective Service (APS) referrals of substantiated incidents. Changes in customers' 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 will be reviewed by the OA and MCO and need for training or other remediation including sanction or termination of provider, will be determined based on circumstances and identified trends and patterns. Resolution or remediation timeframe will be case-specific.

G4: The OA/MCO 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 critical incidents are being

analyzed to determine root cause. Remediation will occur within 30 days.

G5: The OA/MCO will follow up all outstanding APS referrals of substantiated 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 training is provided on alternative practices to restrictive interventions, including restraints and seclusion. Remediation must be completed within 30 days.

G7: If identifying information is available for customer surveys, the OA and the MCO Care Coordinator will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Patterns of negative responses, including anonymous survey responses, will be used to identify need for system improvement.

G8: During the initial evaluation or redetermination, the OA or the MCO Care Coordinator will ask whether the customer has a primary care doctor or practitioner and whether they had a physical in the last 12 months. If not, barriers will be identified and addressed. Remediation will occur at the meeting between the customer and OA or the MCO Care Coordinator.

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS

determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

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

The OA and MA share management reports that track changes in compliance levels for performance measures over time. This includes tracking changes across the entire state as well as by region and provider type. This helps to identify problematic areas and potential best practices. Together, the MA and OA aggregate information and generate reports on a quarterly basis.

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

The state's quality oversight system between the MA and the OA is hierarchical. With regards to waiver management, the process described above is multilevel. The MA oversees the OA, which oversees the individual Care Coordination Units (CCUs), which in turn, oversee the individual Care Coordinators. Consequently, the state's QMS includes regular and structured oversight meetings to facilitate communication, investigation, and problem solving across the many levels. The OA meets with individual CCUs at least quarterly, and more often if required due to performance issues. The OA and MA meet quarterly.

On a quarterly basis, the MA conducts separate meetings with the OA and the MCOs to review data collected from the previous quarter and for the year to date. Data is collected on a regular basis and is reported as indicated by the performance measure in the waiver. All reports will be provided to the MA for review prior to the quarterly meetings. Annual reports are produced to identify trends.

Data is reported by individual performance measures. Data reported includes level of compliance and timeliness of remediation based on immediate, 30, 60, or 90-day increments.

During quarterly meetings, the MA, OA, and/or MCO identify trends based on scope, severity, changes, and patterns of compliance by reviewing both the levels of compliance with the performance measures and remediation activities conducted by the OA and the MCOs. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Systems improvement is prioritized based on the overall impact to the customers and the program. Systems improvements may be prioritized based on factors such as the impact on the health and welfare of waiver customers, legislative considerations, and fiscal considerations. The OA and the MCOs maintain separate quality reporting logs. Recommendations for system improvements are added to the log(s) for tracking purposes.

The OA and the MCOs document the systems improvement implementation activities on its respective log. The MA assures that the recommendations are followed through to completion. Decisions and timelines for system improvement are based on consensus of priority and specific steps needed to accomplish change. These decisions are documented on the systems improvement log and communicated through the sharing of the quarterly meeting summary and the systems improvement log. The MA hosts weekly operational meetings. All MCOs are required to attend. The OA presents at these operational meetings, at least quarterly, on topics related to systems improvement.

The OA shares the following data points with the CCUs monthly: compliance with annual redeterminations and compliance with critical incident follow up reports. The data is aggregated by contract number. The OA shares these reports with the MA at the Waiver quarterly meetings. Additionally, the OA shares the results of the annual Participant Satisfaction Survey with the OAs Advisory groups and specific provider groups that the survey pertains to, e.g. in-home providers. All the data that is shared with the provider network is also shared with the MA at the Waiver quarterly meetings.

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.

For the OA, the state uses the same mechanisms that it uses to identify potential issues including contract compliance, customer satisfaction, assurances, and critical incident analysis to monitor the effectiveness of all interventions. The state tracks changes in the performance measures using data analysis and reports.

For both the OA and MCOs, customer input also plays a central role in the QMS as follows: Customers' perception of the quality of their services using concepts that are meaningful to customers (e.g., integration in the community, dignity, respect, etc.) as gathered through a customer satisfaction survey and the comprehensive care coordination assessment tool. These tools provide the OA and the MCOs with the direct feedback loop about the effect of potential interventions on the quality of life for individual customers. The OA shares results of the customer satisfaction surveys with advisory committees/councils, the MA, and others as appropriate.
The OA, the MCOs, and the MA monitor trends in customers' reports from results using data gathered to assess customer satisfaction. When the OA notices low scores, additional inquiry will be made into the appropriate CCU and provider to determine the root-cause and if additional training or monitoring is warranted. The entities will subsequently use best practices that are identified as a core component of training, in the training of poor performers. The OA may even collaborate and utilize providers who appear to be performing well on this training. The OA subsequently tracks the performance of providers who receive this training to assess the efficacy of the intervention.

In the OA waiver quality plan, the State has implemented additional efforts to address its ability to improve and maintain quality. These include:

1) Updated performance measures in each of the waiver areas,

2) Redesigned reports to be used on a quarterly basis,

3) Updated Critical Event Report system and clearer delineation of critical incident definitions and follow-up procedures including training for CCUs and providers on reporting and management of critical events.

4) Monitoring and managing a training tracking system, and

5) Continue implementing a new case note system.

The OA meets with the Community Care Program Advisory Committee (CCPAC) six times a year to present information about the waiver and receive input from providers, stakeholders, and customer representatives. The CCPAC has several subcommittees as identified in the bylaws, including a services committee where quality issues are discussed. This process of inclusion of stakeholders has been most effective and is viewed by the OA as a critical element in its QMS. Meeting dates and times are shared with the MA for their information and participation.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

During the separate quarterly meetings, the MA reviews waiver reports and the Quality Improvement Strategies with the OA or MCO. The OA, MCOs, and the MA, as partners discuss updates that each entity needs to address in the future. The OA also seeks input from its advisory groups on improvements and/or changes to the Quality Improvement Strategy. The OA and MCOs continually address issues as they arise, respond and implement strategies to improve compliance with performance indicators. The whole QMS is viewed as a continuous ongoing process.

One QMC meeting a year is dedicated as a combined meeting with the MA, the OA, and the MCOs. At this meeting, the entities meet and discuss statewide issues impacting the waiver. During this annual meeting, the OA and the MCOs have on the agenda an overview of the previous year's activities and a discussion of whether changes are needed to the Quality Management Strategy. The MA and the OA see five primary focus areas: These areas are described below.

1) Structure of the QMC: The group reviews the structure of the QMC to determine if it is effective.

2) Trend Analysis: The group evaluates the processes for identifying trends, patterns, and root causes to assure issues are being identified and analyzed.

3) Systems Improvement Log: The group reviews the QMC systems improvement tracking log to assure all recommendations have been implemented in accordance with agreed upon timelines, and if not, whether there is justification.

4) System Improvement Priorities: The methods for determining system improvement priorities are evaluated to determine effectiveness.

5) Performance Measures: The entities determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures are reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

The state continuously strives to increase the compliance rate of each performance measure. While the target compliance rate for each performance measure is 100%, the state realizes it may take multiple system changes over several years to reach the goal of 100% compliance, considering all entities involve experience staff changes that require ongoing training.

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 administers the annual Participant Satisfaction survey. The Participant Satisfaction surveys go to a representative sample of customers receiving waiver services. The Participant Satisfaction survey is specific to Care Coordination and each of the 4 core waiver services (adult day services, in-home services, emergency home response services and automated medication dispenser services). The OA follows up with customers directly in response to feedback or note of concerns. Survey results are analyzed, shared and discussed with waiver service providers for the purpose of ensuring customer satisfaction.

The MCOs conduct an annual HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The survey sampling and administration must follow specifications contained in the most current HEDIS® volume. The MCOs must contract with an NCQA certified HEDIS® survey vendor to administer the survey and submit results as provided in the HEDIS® survey specifications. The MCOs submit a report of the findings and the to the MA.

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;

Independent audits of in-home service provider agencies are required by rule 240.1525(b)(1)-(2) and Section 240.1420 (v)(1-2) for Care Coordination Units (CCUs). The audits must be conducted annually by an independent Certified Public Accountant and submitted to the Operating Agency (OA) for review. Staff in the Bureau of Business Services review the audits and ensure each agency required to complete an audit has done so. Any deficiencies or lack of submitted audit(s) are reported to the Office of Community Care Services who initiate corrective and/or contract action on the provider agency until such time as the deficiency is corrected.

(b) The financial audit program that the State conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits;

The OA and Medicaid Agency (MA) work cooperatively to review rates and provider claims. The MA implements procedures that provide assurance that claims will be coded and paid in accordance with the reimbursement methodology specified in the waiver.

The OA has mechanisms in place to ensure all billings are coded and reimbursed accurately. Edits in the case management system ensure the customer is determined to meet all eligibility requirements and eligibility information is entered completely and accurately. The OA's case management system ensures service authorizations align with the customers' eligibility and assessment information to ensure the CCU doesn't authorize more services than allowed. Further, the edits verify customer identification, date of death and Managed Care Organization (MCO) eligibility dates.

The OA's billing system has edits in place to ensure service providers are authorized to bill only if they have an active contract with the OA. The OA's Information Technology and Business Services staff review and update the contract information via an interface between the statewide accounting system and the OA's billing system.
The billing system checks customer authorizations against the provider billing to ensure the customer is authorized for the service(s) at the time the service was provided, the amount of services billed doesn't exceed the amount of services authorized, the amount of services billed doesn't exceed monthly or annual service limits, and the provider is authorized to provide the services.

The billing system also checks to ensure duplicate billings don't get paid. The duplicate billing edit check includes if one provider agency has already billed for a given month and the customer switched providers during that month, and the second provider agency attempts to bill for service that exceeds their portion of the month, the billing system will verify that the second provider agency is authorized and will also reject the billing if that agency bills more than is allowable based on the service authorization. The OA's billing system notifies providers of rejected billings so the provider can correct their errors and resubmit their bills.

Finally, to ensure billing submissions match services provided, Quality Improvement reviews are conducted by the OA for each OA contracted Community Care Program (CCP) provider at least once during each three-year contract cycle. OA staff review Hours of Service Calendars (HOSCs) for a sample of customers during Quality Improvement reviews of Adult Day Service (ADS) and In Home Service (INH) provider agencies. HOSCs are checked for accuracy of completion including signatures of the customer, worker, and supervisor and accurate total number of units. OA staff also compare the number of units on the HOSC to the number of units billed by the provider agency for that month. OA staff uses Electronic Visit Verification (EVV) information to compare against number of units billed.

If the edits and/or staff reviews as outlined above identify the need for the OA to recoup payments, the OA fiscal division sends letters to service providers and Care Coordination Units regarding the amount owed and the process for review and submission of payment. The OA submits the corrected billing through the regular electronic feed to the MA which allows the federal claim to be adjusted.

The MA conducts oversight procedures that provide increased assurance that claims are coded and paid in accordance with the reimbursement methodology specified in the waiver and that customers were enrolled in the waiver on the date of service. These processes enable staff to monitor the financial aspects of the waiver for Persons who are Elderly from a global perspective, rather than review a sample of paid claims.

The MA staff utilizes its Data Warehouse query capability to analyze the entire dataset of paid waiver claims in an effort to identify problematic billings, patterns and/or trends. The MA utilizes a financial exception report to review the agency's financial accountability activity. Data for waiver customers are reviewed quarterly considering nursing home admissions, hospitalized, and death dates, looking for overlapping dates of service to ensure there is no fraudulent or inappropriate

billings. Agency staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year 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. Current exception reports identify paid claims for waiver services to customers who were in a nursing home or who are deceased. In addition to the exception reviews of waiver claims, MA staff conduct targeted reviews of individual waiver services, utilization of waiver services by individual customers and billing trends and patterns of providers. These reviews are usually conducted on an impromptu basis.

The results of all financial reviews are presented to OA personnel under cover memos 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.

(c) The agencies responsible for conducting the financial audit program:

The MA and OA are responsible for ensuring the integrity of payments made for waiver services.

For customers enrolled in Fee-for-Service, the OA internal billing system edits and internal auditing process will ensure payments are made only for eligible customers who have been properly enrolled in the waiver.

For customers enrolled in an MCO, the MA's internal and external auditing procedures will ensure MCOs only receive reimbursement for eligible customers who have been properly enrolled in the waiver.

The MCOs are responsible for reviewing payments made directly to providers for waiver services as part of the HealthChoice Illinois/FIDE SNP. The MCO must have an internal process to validate payments to waiver providers. This includes the claims processing system verifying a customer's waiver eligibility prior to paying claims.

The OA and MA systems have several measures in place to ensure claims describe services rendered and only authorized billings are submitted for claiming.

If the OA rejects billings due to errors, CCUs and provider agencies can review the identified errors and send in a corrective billing through the OA system during the current fiscal year or through the State's court of claims process for prior fiscal years.

Additionally, the MA's Office of Inspector General (OIG) has jurisdiction to investigate concerns of waste, fraud, and abuse. The OA and the MA OIG work closely together to refer concerns for each entity to investigate.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I1: Number and percent of payments made to the OA and MCO for customers who were enrolled in the waiver on the date the service was delivered. N: Number of payments made to the OA and MCO for customers who were enrolled in the waiver on the date the service was delivered. D: Total number of OA and MCO payments.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MCO Encounter Data, MMIS Enterprise Data Warehouse

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

Data Aggregation and Analysis:

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

Performance Measure:
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:
MCO Encounter Data, MMIS Enterprise 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***	☒ ***Annually***	☐ ***Stratified***

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

Data Aggregation and Analysis:

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

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:
MMIS Enterprise Data Warehouse, MCO Encounter Data

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

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.*

For those functions delegated to the Operating Agency (OA) and the Managed Care Organizations (MCOs), the Medicaid Agency (MA) is responsible for oversight and monitoring to ensure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the OA and MCOs through fiscal monitoring and ongoing reporting by the OA and MCO.

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a +/-5% margin of error. The MA will pull the sample annually.

For the administrative claims review, the MA reviews the entire MA claim related to Medicaid administrative costs.

For the waiver claims review, the MA staff utilize the Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The MA utilizes an exception report and review format as a component of the agency's financial accountability activity. MA staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year 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. This review will include capitation payments made to MCOs and encounter claims submitted by MCOs.

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

Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver customers enrolled in an MCO through customer surveys and quarterly record reviews. Customers in MCOs are included in the representative sampling.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In*

addition, provide information on the methods used by the state to document these items.

I1: The MA will require the OA to void the federal claim for services provided prior to the customers' waiver enrollment. Remediation must be completed within 30 days. The MA will adjust the federal claim for services provided by the MCO prior to the customers' waiver enrollment. Remediation must be completed within 30 days.

I2: The OA/MCO will determine whether the service was coded and paid correctly. If coded and/or paid incorrectly, the OA/MCO 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:* *MCO*	☐ ***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.

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 Medicaid Agency (MA) solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the waiver are proposed. The notice is published in accordance with Federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Whenever rates change, a listing of all covered services and corresponding rates are made available to customers and guardians (when applicable), family members, providers, stakeholders, and any interested parties. All rates are posted on the Operating Agency (OA)'s website and updated within 30 days of any rate change. The MA's Home and Community Based Services webpage contains links to each waiver program's rate tables.

The MA retains and exercises final authority over payment rates. It does so in collaboration with the OA, which develops the proposed rates and shares the proposed rates and methodologies with the MA. The process for establishing and updating payment rates, effective since the initial waiver approval, are described below.

The OA will review the rates paid for the Community Care Program (CCP) services within 5 years from the previous review. The OA entered a contract on October 7, 2025 to conduct a rate study for all CCP waiver services and all case management services billed by the Care Coordination Units (CCUs).

In addition to this rate review process, the rates for each waiver service are reviewed annually to ensure budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. In reviewing fixed unit rates of reimbursement, the OA takes into consideration (1) service utilization and cost information, and (2) current market conditions and trend analyses.

Emergency Home Response Service (EHRS):

When developing the rate, the OA reviewed Medicaid reimbursement rates paid in other states, as well as analyzed installation costs incurred by existing contracted and non-contracted providers. The OA examined the cost components underlying into the installation activity, which could include administrative costs (completing paperwork, contacting the customer, scheduling an appointment), training and testing (include training the customer to properly use the device and testing the range capacity within the device) and the cost of transportation to the customer's home to perform the installation. Based on this analysis, the OA employs a methodology of frequent, ongoing review to ensure the installation rate remains in line with similarly situated programs in other states and is reflective of the cost of providing the installation service.

Rates are not geographically based.

EHRS rate, as of 10/01/26, for basic and GPS units is $28.00/month.
EHRS rate, as of 10/01/26, for Fall Detection units is $37.00/month.
The one-time installation rate, as of 10/01/26, for all units (basic, GPS, and Fall Detection) is $40.00/event.

Adult Day Service (ADS) and Adult Day Service (ADS) Transportation:

These rates were originally established by legislation. The OA used multiple means to obtain necessary data to complete a thorough rate analysis for the ADS program and ADS Transportation. This process included conducting focus groups which included customers, stakeholders, reviewing existing state data, and developing and distributing two provider surveys.

The ADS rate is based on a fee-for-service structure. Providers are paid on an hourly basis for ADS services. The ADS Transportation rate is a separate fixed fee for service rate calculated independently of the ADS rate. Providers are paid per one-way trip for ADS Transportation.

Rates are not geographically based.

The Adult Day Service rate, as of 10/01/26, is $16.84 an hour/unit.
The Adult Day Service Transportation rate, as of 10/01/26, is $12.44 per one-way trip.

In-Home Service (INH):

The INH rate was originally established by requesting information from providers on their costs for providing the service

and the size of the population each provider projected it could serve. The rate is designed to include both administrative and direct service costs. The rate is not geographically based. The INH rate is based on a fee-for-service structure. Providers are paid on an hourly basis for INH services. The OA also offers an additional enhanced rate to those INH providers that offer health insurance coverage as a benefit to their direct service worker employees.

The INH rate, effective 10/1/26, is $30.80 an hour/unit.
The INH enhanced rate, effective 10/1/26, for insurance is $1.77 an hour/unit for a total rate of $32.57 an hour/unit.

Automated Medication Dispenser (AMD):

The AMD rate was originally established through a Request For Information (RFI) process that allowed for the calculation and subsequent establishment of a fixed rate and research on other states' approaches to obtaining Medicaid reimbursement for the provision of AMD services. The RFI requested information on monthly rates, unit specifications and installation costs.

Rates are not geographically based and do not include the filling of the medication dispensers.

The current rate for AMD monthly service rate, as of 10/01/26, is $40.00/month.
AMD one-time installation rate, as of 10/01/26, is $50.00/event.

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:*

Fee-for-Service Providers are paid by the Operating Agency (OA). Claims submitted by the provider are generated through the OA billing system. The OA will not accept a claim for payment unless the service has been authorized and verified in the case management system. The OA billing system provides authorized services and service cost maximums for the customer as per the determination of need/assessment. Billings are rejected if the customer is enrolled in a Managed Care Organization (MCO), and the provider will be directed to submit the bill to the appropriate MCO for reimbursement. Billings will also be rejected if the customer is identified on the State's Public Health death record as deceased on the date of service. Authorized billings are entered into the statewide accounting system via an electronic interface. The files are reviewed by the OA's fiscal department. Once approved, the files are submitted to the State's Comptroller's office for payment.

Valid waiver service authorization submissions are submitted to the Medicaid Agency (MA) on a weekly basis to determine Medicaid eligibility. The MA returns daily eligibility files to the OA with an OBRA code for all those customers who meet the eligibility criteria. Customers who were not returned with an OBRA code are researched by the OA staff and re-submitted. If issues are corrected, the MA will provide the OA OBRA indicator code. If the customer is enrolled in Medicaid and meets the qualifications for managed care, the customer will be enrolled in an MCO. All billings that were accepted by the MA from the OA with the OBRA indicator code are eligible for federal financial participation. Federal financial claiming is submitted by the MA.

To ensure billing matches services provided, Quality Improvement (QI) reviews are conducted by the OA for each contracted Community Care Program (CCP) provider at least once during a contract cycle (3 years). The review is performed by OA staff as an independent desk review. This ongoing administrative activity allows the OA to ensure that providers and Care Coordination Units (CCUs) are adhering to the rules, regulations, policies, and procedures of CCP.

CCP service billings are reviewed by the OA. The OA chooses a random stratified sample from their billing records. If the OA is aware of a particular customer's concern via the complaint/SIP process or other means, the customer's file is included in the sample. A minimum of 5 customer files are chosen for each contract number reviewed unless a contract has less than 5 customers. If fewer than 5 customers, the review includes all customers.

Documentation reviewed includes, but is not limited to, date of initiation of service, complaint follow-up, reporting concerns to the CCU, etc. Verification is also thoroughly reviewed that billing submitted to the OA by the provider matches what the customer acknowledged for provision of service, including dates, and start/stop times by the homecare aide. Because Personal Care Services are subject to Electronic Visit Verification (EVV), the In-home service providers are required to utilize EVV to electronically track and document time spent by the homecare aide in the customer's residence. The OA currently operates a compliant EVV system for personal care services in this waiver.

Any billing errors found during the QI review require the provider agency to work with the OA to correct the error. Claims will be adjusted if applicable.

Monthly capitated rates are paid by the MA to the MCO. This payment is generated by the Medicaid Management Information Systems (MMIS) based on the customer's eligibility for waiver services as identified in the database through the OBRA code. The MCOs only receive payment for customers eligible for waiver services. The MCO payment process is automated to generate a monthly capitation to the MCOs based on the rate cell of each customer each month. The MA reviews to ensure the accurate rate is entered into the system, and spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report any discrepancies to the MA.

In general, the rate cells for the Medicaid Component are stratified by age (21-64 and 65+), geographic service area (Greater Chicago and Central Illinois), and setting-of-care. Capitation Rate updates will take place on January 1st of each calendar year. MCOs will be provided a rate report, to be signed by MA and MCO, on an annual basis for the upcoming calendar year.

The State has a monthly capitation program that reads the State's Recipient Database to determine who is enrolled with a particular MCO. The program includes logic that uses the customer's eligibility criteria to determine the appropriate rate cell to be used in generating the payment. As a result of this process, a file is created of MCO schedules which are then sent on to the Comptroller for payment. Once the payment has been made by the Comptroller, a file is sent back to the MA by the Comptroller that includes a warrant number and date. The MA then creates a HIPAA 820 file for each MCO. The 820 file contains the detailed payment information on each of the MCO's enrollees. The MCOs are required

to have internal processes to validate payments to waiver providers. The MCO's claims processing system must verify a customer's waiver eligibility prior to paying claims.

Lastly, the MA performs post-payment financial reviews.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

(a) when the individual was eligible for Medicaid waiver payment on the date of service

Provider billings are validated by the Medicaid Agency (MA) to verify the effective date of the customer's authorization for services as included in an approved Person-Centered Plan (PCP). Paid Claims are passed through to the MA and Medicaid Management Information Systems (MMIS) processing edits are initiated for Medicaid and waiver eligibility. Lastly, the MA performs post-payment PCP and financial reviews.

(b) when the service was included in the participant's approved service plan

Oversight to ensure appropriate services were provided occurs in a variety of methods. Working with the customer/authorized representative, the Care Coordinator authorizes the appropriate type and amount of services via a signed Customer Agreement. This information is included in the Operating Agencies (OA's) billing system through which Care Coordination Units (CCUs) and providers submit billings to the OA. The billing system contains several features designed to ensure appropriate billing and services, including: 1) billing system security measures do not allow for unauthorized providers to submit billings; 2) CCUs and providers cannot submit billings that are not authorized; 3) Providers cannot submit billings over the authorized amount; and 4) Customers/authorized representatives acknowledge services provided by providers via signed electronic or paper means.

For customers enrolled in managed cares, monthly capitated rates are paid by the MA to the Managed Care Organization (MCO). This payment is generated by the MMIS based on the customer's eligibility for waiver services as identified in the database system. The MCO payment process is automated to generate a monthly capitation to the MCOs based on the rate cell of each customer, each month. The MA reviews to ensure the accurate rate is entered into the system and also spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report to the MA any discrepancies. Lastly, the MA performs post payment financial reviews. The MCOs are required to have internal processes to validate payments to waiver providers. The MCO claims processing system must verify a customer's waiver eligibility prior to paying claims. The MCO payment process is automated to generate a monthly capitation to the MCOs based on the rate cell of each customer each month. The State reviews to ensure the accurate rate is entered into the system and also spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report to the MA for discrepancies.

(C) the services were provided

Customers/authorized representatives are required to acknowledge via electronic or paper signature on hours of service calendars that services were provided. In-home service providers are also required to utilize an electronic visit verification (EVV) system to verify services were provided to the customer. The OA reviews EVV records, signed hours of service calendars and provider billing records during quality assurance reviews to ensure services were provided and billed for correctly.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

The Operating Agency (OA) makes payments through the statewide accounting system and submits to the comptroller's office for payment. Claims are then sent to the Medicaid Agency (MA) for further editing and for Medicaid claiming. The audit trail is established through State agency approved rates, Person-Centered Plan (PCP) authorizations, documentation of service delivery, and computerized payment and claiming systems cross-matched with the Medicaid Management Information Systems (MMIS).

Monthly capitated rates are paid by the MA to the Managed Care Organization (MCO). This payment is generated by the MMIS based on customer's eligibility for waiver services as identified in the database system. The MCOs receive a specific payment for those eligible for waiver services.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The limited fiscal agent is a function of the Operating Agency (OA).

The OA passes the detailed expenditure data via an electronic tape to the MA, the Single Statewide Medicaid claiming agency for the State of Illinois. The data is fed into the Medical Management Information System (MMIS) and is subject to edits to ensure the information provided is accurate and the services/providers are eligible for federal match under Title XIX. Should any claims have inaccurate information, those claims are rejected by the system and a file of the rejected claims is passed back to the OA for their review. Claims that pass through the system without error pass into the Management Administrative Reporting System (MARS) reporting unit. The MARS unit is responsible for generating the reports to the Bureau of Federal Finance (BFF) who use the reports to claim Medicaid expenditure data quarterly on the CMS 64. MARS also has a series of edits and codes that are used to filter data to ensure accuracy and to determine to what program the expenditure should be reported. The BFF reports the expenditures on the CMS 64 on a quarterly basis 30 days after the quarter's end.

In accordance with the Cash Management Improvement Act (CMIA), the BFF draws down federal monies from the Title XIX grant for the waiver on a weekly basis and deposits the funds into the General Revenue Fund (GRF). The amount to be drawn is an estimate derived by using historical expenditure data. Once the CMS 64 is completed at the quarter's end, the BFF reconciles the estimated cash draw to the actual expenditures reported on the CMS 64. The reconciling expenditure amount is either added to or subtracted from the grant award depending on whether the adjustment is over or under the original estimated amount.

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Not applicable.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

○ ***No. The state does not make supplemental or enhanced payments for waiver services.***

◉ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

(a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made

The Operating Agency (OA) has one service, the in-home service (INH), that permits an enhanced rate.

(b) the types of providers to which such payments are made

This enhanced rate is only for INH provider agencies that provide health insurance in accordance with 89 Ill. Adm. 240.1970. INH providers must submit proof to the OA that they meet the requirements.

(c) the source of the non-Federal share of the supplemental or enhanced payment

The source of the non-federal share of the enhanced payments is the State of Illinois.

(d) whether providers eligible to receive the supplemental or enhanced payment retail 100% of the total computable expenditure claimed by the state to CMS.

Each service provider that received the enhanced rate retains 100% of the total computable expenditure claimed by the Medicaid Agency to CMS. The OA automatically adds the enhanced rate to eligible provider billings.

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:

County and other local government providers may be authorized to provide in home services (INH) and Adult Day Services (ADS).

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess***

and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Waiver providers must receive and retain 100 percent of the total computable expenditure claimed by the Medicaid agency to CMS.

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.

Illinois Department on Aging

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:

The OA receives the non-federal share through general state fund appropriations.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that*

make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

Check each that applies:

- ☐ ***Health care-related taxes or fees***
- ☐ ***Provider-related donations***
- ☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	20033.85	4937.16	24971.01	64360.33	7607.91	71968.24	46997.23
2	22261.02	5258.63	27519.65	68349.88	8324.92	76674.80	49155.15
3	24602.28	5570.49	30172.77	72190.67	9060.57	81251.24	51078.47
4	27268.35	5917.03	33185.38	76456.21	9889.09	86345.30	53159.92
5	30216.85	6285.15	36502.00	80973.83	10794.32	91768.15	55266.15

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	160164	160164

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 2	160164	160164
Year 3	160164	160164
Year 4	160164	160164
Year 5	160164	160164

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay was projected based on actual experience from the current waiver period. The calculations of the ALOS estimate of 287 for WY 1 in the renewal period is equal to the projected total number of days for members on the waiver during WY 1 divided by the unduplicated participant count (46,017,414/160,164). The State did not assume any growth in waiver slots during the renewal period based on a review of current unduplicated participant counts and the assumed counts in WY 5 of the current waiver period.

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:*

Base Year data reflects projections from the experience incurred during the state fiscal year 2024 period of July 1, 2023 through June 30, 2024 (SFY 2024). The sources of information for these future projections was provided by the Medicaid Agency (MA) from MMIS. We adjusted the experience for some missing encounter claims and utilization not reported in the correct unit base. We adjusted utilization to account for known deficiencies in the experience based on a comparison of encounter data and health plan reported financial data. Additionally, we adjusted the total units to account for known discrepancies among the health plans for the reporting of units for different services. For example, one health plan may have entered units as hours, but another may have entered units in 15-minute increments. These processes are consistent with the methodology utilized in the development of the capitation rates for the broader population. We also increased the utilization of Emergency Home Response Service with Fall Detection services and installations because these services were new during the experience period and utilization is expected to increase.

Factor D for the new 5-year waiver period for the renewal (October 1, 2026 through September 30, 2031) was projected from SFY 2024 in the following manner:

Unduplicated participants were projected based on total projected slots.

The count of unduplicated users per 1,000 total participants from the adjusted SFY2024 experience was utilized as the basis for projecting unduplicated users by category of service for all waiver services. As such, the growth in unique users for each service category between waiver years is a function of the growth of unduplicated users by category of service for each waiver year relative to the base period. For example, the 76,984 for In-home services (homemaker) in waiver year one of the renewal period is equal to 58,185 (# of users in the base period) multiplied by the change in unduplicated participants from the base period to WY1 (160,164/121,053). We did not assume any trend for the number of users for the homemaker service. Other services are adjusted to reflect user trends. For Adult Day Service and Adult Day Service Transportation, we assumed a 10.0% annual growth of users. The trend estimate was developed from reviewing SFY 2022 through SFY 2025 experience. For Automated Medication Dispenser (service and install) and Emergency Home Response (service, install, and fall detection), we assumed a 5.1% annual growth in users, consistent with annualized waiver trends in CY 2025 HealthChoice Illinois capitation rate development.

Average units per user were projected to vary with average length of stay and adjusted for trend.

The adjusted SFY 2024 experience was utilized as the basis for projecting average units per user per category of service. We applied a 5.1% annual trend to In-Home Service (Homemaker) to develop estimates for the waiver period. Trend assumptions are consistent with annualized waiver trends in CY 2025 HealthChoice Illinois capitation rate development. Amounts for WY2 through WY5 were calculated by multiplying the prior year average units per user by the change in ALOS between waiver years and adjusted for trend. We project ALOS to be approximately 1 day higher in WY 2 due to the presence of a leap day. As an example, the 760.18 units per user of capitated in-home service (homemaker) in WY 2 of the renewal period is equal to (# of units per user from WY1) multiplied by the change in ALOS from WY1 to WY2 (288/287) and one year of trend (approximately 1.051).

Average cost per unit was developed by trending SFY 2024 reimbursement to the midpoint of each waiver year:

Homemaker: Fee schedule increases are known through January 1, 2026. Subsequent trends were estimated as the annualized reimbursement change between January 1, 2022 and January 1, 2026.

Adult Day Service and Adult Day Transportation: Trends were estimated as the annualized reimbursement change between January 1, 2022 and January 1, 2025.
Automated Medication Dispenser (Service and Install) and Personal Emergency Response Systems (Monitoring and Install): Trends were assumed to be 2.3%, consistent with the annualized change in the Producer Price Index (PPI) for Medical Equipment and Supplies between August 2023 and August 2025.

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:*

To estimate Factor D' costs, we leveraged CY 2025 HealthChoice and MMAI capitation rate development for managed care eligible members. Additionally, we leveraged MMIS claims and enrollment data received through October 2025 for enrollees ineligible for managed care (managed care ineligible members) as well as services covered outside of managed care.

- For managed care eligible members, base benefit expenses reflect CY 2025 per member per month (PMPM) benefit expenses for non-waiver services reflected in the CY 2025 capitation rates for Other Waiver rate cells. We added fee-for-service costs for non-waiver services not covered under managed care. The Other Waiver rate cells also include members in other 1915(c) waivers; we applied an acuity adjustment to each rate cell to reflect the acuity of the existing Persons who are Elderly waiver populations relative to the average member month in the Other Waiver rate cells.

- For managed care ineligible members, base benefit expenses reflect fee-for-service (FFS) CY 2024 PMPM non-waiver expenditures for Medicaid enrollees with an open Persons who are Elderly waiver segment.

To estimate Factor D', we trended non-waiver PMPM base benefit expenses from the midpoint of the base experience period to the midpoint of each waiver year. We sourced trend assumptions of approximately 6.2% from CY 2025 capitation rate development for Other Waiver rate cells, reflecting both cost and utilization changes. We composited PMPMs across rate cells and ineligible members using the January 2025 Persons who are Elderly waiver enrollment distribution. We annualized PMPM costs for each waiver year using the projected average length of stay (ALOS).

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:*

The comparable population was identified using age criteria aligned with the targeted Persons who are Elderly population. We leveraged CY 2025 HealthChoice and MMAI capitation rate development for managed care eligible members. Additionally, we leveraged MMIS claims and enrollment data received through October 2025 for managed care ineligible members as well as services covered outside of managed care.

- For managed care eligible members, base benefits reflect CY 2025 PMPM benefit expenses for institutional services reflected in the CY 2025 capitation rates for Nursing Facility rate cells.

- For managed care ineligible members, base benefit expenses reflect FFS CY 2024 PMPM institutional expenditures for Medicaid enrollees with a comparable level of care institutionalized in a nursing facility during that month.

To estimate Factor G, we trended institutional PMPM base benefit expenses from the midpoint of the base experience period to the midpoint of each waiver year. We sourced cost trend assumptions of approximately 5.9% using annualized changes in Illinois nursing facility reimbursement from January 2017 to October 2025. We composited PMPMs across rate cells and ineligible members using the January 2025 Persons who are Elderly waiver enrollment distribution. We annualized PMPM costs for each waiver year using the projected ALOS.

Estimates of Factor G are illustrated in the cost neutrality summary in Appendix J-1 Composite Overview and Demonstration of Cost Neutrality Formula.

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:*

To estimate Factor G' costs, we leveraged PMPM benefit expenses for non-institutional services reflected in the CY 2025 HealthChoice and MMAI capitation rates for Nursing Facility rate cells. Additionally, we leveraged MMIS claims and enrollment data received through October 2025 for managed care ineligible members.

- For managed care eligible members, base benefit expenses reflect CY 2025 for non-institutional services reflected in the CY 2025 capitation rates for Nursing Facility rate cells. We also added fee-for-service costs for non-institutional services not covered under managed care.

- For managed care ineligible members, base benefit expenses reflect FFS CY 2024 PMPM non-institutional expenditures for the members identified in Factor G development.

To estimate Factor G', we trended non-institutional PMPM base benefit expenses from the midpoint of the base experience period to the midpoint of each waiver year. We sourced trend assumptions of approximately 9.1% from CY 2025 capitation rate development for Nursing Facility rate cells. We composited PMPMs across rate cells and ineligible members using the January 2025 Persons who are Elderly enrollment distribution. We annualized PMPM costs for each waiver year using the projected ALOS.

Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary in Appendix J-1 Composite Overview and Demonstration of Cost Neutrality Formula.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Service	
In-Home Service	
Automated Medication Dispenser	
Emergency Home Response Service	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**69050589.76**
Adult Day Service	☒	Hour	3674	560.20	17.83	**36697256.68**	
Adult Day Service -FFS	☐	Hour	2478	442.07	17.83	**19531863.87**	
Adult Day Transportation	☒	Trip	6810	96.80	13.18	**8688361.44**	
Adult Day Transportation - FFS	☐	Trip	2231	140.56	13.18	**4133107.76**	
In-Home Service Total:							**3116242890.30**
In-Home Service (Homemaker)	☒	Hour	76984	721.28	33.91	**1882921231.92**	
In-Home Service (Homemaker) - FFS	☐	Hour	69526	523.12	33.91	**1233321658.38**	
Automated Medication Dispenser Total:							**118520.80**
Automated Medication Dispenser Service	☒	Month	75	6.69	43.05	**21600.34**	
Automated Medication Dispenser Service - FFS	☐	Month	355	6.12	43.05	**93530.43**	
Automated Medication Dispenser Installation	☒	Service	10	1.00	53.81	**538.10**	
Automated Medication Dispenser Installation - FFS	☐	Service	53	1.00	53.81	**2851.93**	
Emergency Home Response Service Total:							**23289484.00**
Emergency Home Response Service	☒	Month	43663	8.65	30.13	**11379647.54**	
Emergency Home Response Service - FFS	☐	Month	39055	6.65	30.13	**7825235.55**	
Emergency Home Response	☒	Service	6498	1.00	43.05	**279738.90**	

GRAND TOTAL: **3208701484.86**

Total: Services included in capitation: 1941894642.75

Total: Services not included in capitation: 1266806842.11

Total Estimated Unduplicated Participants: **160164**

Factor D (Divide total by number of participants): **20033.85**

Services included in capitation: 12124.41

Services not included in capitation: 7909.44

Average Length of Stay on the Waiver: 287

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service Install							
Emergency Home Response Service Install - FSS	☐	Service	4495	1.00	43.05	193509.75	
Emergency Home Response Service with Fall Detection	☒	Month	6898	6.94	39.82	1906267.82	
Emergency Home Response Service with Fall Detection - FFS	☐	Month	6170	6.94	39.82	1705084.44	

GRAND TOTAL: 3208701484.86
Total: Services included in capitation: 1941894642.75
Total: Services not included in capitation: 1266806842.11
Total Estimated Unduplicated Participants: 160164
Factor D (Divide total by number of participants): 20033.85
Services included in capitation: 12124.41
Services not included in capitation: 7909.44
Average Length of Stay on the Waiver: 287

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							78640206.72
Adult Day Service	☒	Hour	4041	561.73	18.41	41789796.62	
Adult Day Service -FFS	☐	Hour	2726	443.28	18.41	22246299.36	
Adult Day Transportation	☒	Trip	7491	97.07	13.61	9896530.15	

GRAND TOTAL: 3565414495.34
Total: Services included in capitation: 2157894461.51
Total: Services not included in capitation: 1407520033.82
Total Estimated Unduplicated Participants: 160164
Factor D (Divide total by number of participants): 22261.02
Services included in capitation: 13473.03
Services not included in capitation: 8787.99
Average Length of Stay on the Waiver: 288

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Transportation - FFS	☐	Trip	2454	140.95	13.61	4707580.59	
In-Home Service Total:							3461542899.86
In-Home Service (Homemaker)	☒	Hour	76984	760.18	35.74	2091565455.07	
In-Home Service (Homemaker) - FFS	☐	Hour	69526	551.33	35.74	1369977444.79	
Automated Medication Dispenser Total:							127865.26
Automated Medication Dispenser Service	☒	Month	79	6.71	44.03	23339.86	
Automated Medication Dispenser Service - FFS	☐	Month	373	6.14	44.03	100838.39	
Automated Medication Dispenser Installation	☒	Service	11	1.00	55.03	605.33	
Automated Medication Dispenser Installation - FFS	☐	Service	56	1.00	55.03	3081.68	
Emergency Home Response Service Total:							25103523.49
Emergency Home Response Service	☒	Month	45892	8.67	30.82	12262773.78	
Emergency Home Response Service - FFS	☐	Month	41049	6.67	30.82	8438418.30	
Emergency Home Response Service Install	☒	Service	6830	1.00	44.03	300724.90	
Emergency Home Response Service Install - FSS	☐	Service	4724	1.00	44.03	207997.72	
Emergency Home Response Service with Fall Detection	☒	Month	7250	6.96	40.73	2055235.80	

GRAND TOTAL: 3565414495.34

Total: Services included in capitation: 2157894461.51

Total: Services not included in capitation: 1407520033.82

Total Estimated Unduplicated Participants: 160164

Factor D (Divide total by number of participants): 22261.02

Services included in capitation: 13473.03

Services not included in capitation: 8787.99

Average Length of Stay on the Waiver: 288

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Home Response Service with Fall Detection - FFS	☐	Month	6485	6.96	40.73	1838372.99	

GRAND TOTAL: 3565414495.34
Total: Services included in capitation: 2157894461.51
Total: Services not included in capitation: 1407520033.82
Total Estimated Unduplicated Participants: 160164
Factor D (Divide total by number of participants): 22261.02
Services included in capitation: 13473.03
Services not included in capitation: 8787.99
Average Length of Stay on the Waiver: 288

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							89088108.61
Adult Day Service	☒	Hour	4445	560.20	19.01	47336591.89	
Adult Day Service -FFS	☐	Hour	2999	442.07	19.01	25202848.35	
Adult Day Transportation	☒	Trip	8240	96.80	14.06	11214705.92	
Adult Day Transportation - FFS	☐	Trip	2699	140.56	14.06	5333962.45	
In-Home Service Total:							3824258444.45
In-Home Service (Homemaker)	☒	Hour	76984	796.81	37.67	2310738864.58	
In-Home Service (Homemaker)	☐	Hour	69526	577.89	37.67	1513519579.87	

GRAND TOTAL: 3940398882.08
Total: Services included in capitation: 2384993385.77
Total: Services not included in capitation: 1555405496.31
Total Estimated Unduplicated Participants: 160164
Factor D (Divide total by number of participants): 24602.28
Services included in capitation: 14890.95
Services not included in capitation: 9711.33
Average Length of Stay on the Waiver: 287

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
- FFS							
Automated Medication Dispenser Total:							**137029.17**
Automated Medication Dispenser Service	☒	Month	83	6.69	45.03	**25003.81**	
Automated Medication Dispenser Service - FFS	☐	Month	392	6.12	45.03	**108028.77**	
Automated Medication Dispenser Installation	☒	Service	12	1.00	56.29	**675.48**	
Automated Medication Dispenser Installation - FFS	☐	Service	59	1.00	56.29	**3321.11**	
Emergency Home Response Service Total:							**26915299.85**
Emergency Home Response Service	☒	Month	48235	8.65	31.52	**13151176.28**	
Emergency Home Response Service - FFS	☐	Month	43145	6.65	31.52	**9043537.16**	
Emergency Home Response Service Install	☒	Service	7179	1.00	45.03	**323270.37**	
Emergency Home Response Service Install - FSS	☐	Service	4965	1.00	45.03	**223573.95**	
Emergency Home Response Service with Fall Detection	☒	Month	7620	6.94	41.66	**2203097.45**	
Emergency Home Response Service with Fall Detection - FFS	☐	Month	6816	6.94	41.66	**1970644.65**	

GRAND TOTAL: **3940398882.08**

Total: Services included in capitation: 2384993385.77

Total: Services not included in capitation: 1555405496.31

Total Estimated Unduplicated Participants: **160164**

Factor D (Divide total by number of participants): **24602.28**

Services included in capitation: 14890.95

Services not included in capitation: 9711.33

Average Length of Stay on the Waiver: 287

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Service Total:							***101159490.20***
Adult Day Service	☒	*Hour*	*4890*	*560.20*	*19.62*	***53746596.36***	
Adult Day Service -FFS	☐	*Hour*	*3299*	*442.07*	*19.62*	***28613590.81***	
Adult Day Transportation	☒	*Trip*	*9064*	*96.80*	*14.52*	***12739778.30***	
Adult Day Transportation - FFS	☐	*Trip*	*2969*	*140.56*	*14.52*	***6059524.73***	
In-Home Service Total:							***4237165301.08***
In-Home Service (Homemaker)	☒	*Hour*	*76984*	*837.49*	*39.71*	***2560235940.65***	
In-Home Service (Homemaker) - FFS	☐	*Hour*	*69526*	*607.39*	*39.71*	***1676929360.43***	
Automated Medication Dispenser Total:							***147264.33***
Automated Medication Dispenser Service	☒	*Month*	*87*	*6.69*	*46.06*	***26808.30***	
Automated Medication Dispenser Service - FFS	☐	*Month*	*412*	*6.12*	*46.06*	***116137.53***	
Automated Medication Dispenser Installation	☒	*Service*	*13*	*1.00*	*57.58*	***748.54***	
Automated Medication Dispenser Installation - FFS	☐	*Service*	*62*	*1.00*	*57.58*	***3569.96***	
Emergency Home Response Service							***28935329.58***

GRAND TOTAL: ***4367407385.19***

Total: Services included in capitation: *2643603940.05*

Total: Services not included in capitation: *1723803445.14*

Total Estimated Unduplicated Participants: ***160164***

Factor D (Divide total by number of participants): ***27268.35***

Services included in capitation: *16505.61*

Services not included in capitation: *10762.74*

Average Length of Stay on the Waiver: *287*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Emergency Home Response Service	☒	Month	50697	8.65	32.24	**14138176.57**	
Emergency Home Response Service - FFS	☐	Month	45348	6.65	32.24	**9722429.81**	
Emergency Home Response Service Install	☒	Service	7545	1.00	46.06	**347522.70**	
Emergency Home Response Service Install - FSS	☐	Service	5218	1.00	46.06	**240341.08**	
Emergency Home Response Service with Fall Detection	☒	Month	8009	6.94	42.61	**2368368.62**	
Emergency Home Response Service with Fall Detection - FFS	☐	Month	7164	6.94	42.61	**2118490.80**	

GRAND TOTAL: **4367407385.19**

Total: Services included in capitation: 2643603940.05

Total: Services not included in capitation: 1723803445.14

Total Estimated Unduplicated Participants: **160164**

Factor D (Divide total by number of participants): **27268.35**

Services included in capitation: 16505.61

Services not included in capitation: 10762.74

Average Length of Stay on the Waiver: 287

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**114914803.84**
Adult Day Service	☒	Hour	5379	560.20	20.26	**61049778.11**	
Adult Day Service -FFS	☐	Hour	3629	442.07	20.26	**32502551.33**	
Adult Day Transportation	☒	Trip	9970	96.80	15.00	**14476440.00**	
Adult Day Transportation - FFS	☐	Trip	3266	140.56	15.00	**6886034.40**	
In-Home Service Total:							**4693468902.34**
In-Home Service (Homemaker)	☒	Hour	76984	880.24	41.85	**2835939979.30**	
In-Home Service (Homemaker) - FFS	☐	Hour	69526	638.40	41.85	**1857528923.04**	
Automated Medication Dispenser Total:							**158172.02**
Automated Medication Dispenser Service	☒	Month	91	6.69	47.11	**28680.10**	
Automated Medication Dispenser Service - FFS	☐	Month	433	6.12	47.11	**124839.62**	
Automated Medication Dispenser Installation	☒	Service	14	1.00	58.89	**824.46**	
Automated Medication Dispenser Installation - FFS	☐	Service	65	1.00	58.89	**3827.85**	
Emergency Home Response Service Total:							**31109620.71**
Emergency Home Response Service	☒	Month	53285	8.65	32.98	**15200984.94**	
Emergency Home Response Service - FFS	☐	Month	47663	6.65	32.98	**10453306.17**	
Emergency Home Response	☒	Service	7930	1.00	47.11	**373582.30**	

GRAND TOTAL: **4839651498.90**

Total: Services included in capitation: *2929616252.90*

Total: Services not included in capitation: *1910035246.00*

Total Estimated Unduplicated Participants: **160164**

Factor D (Divide total by number of participants): **30216.85**

Services included in capitation: *18291.35*

Services not included in capitation: *11925.50*

Average Length of Stay on the Waiver: 287

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service Install							
Emergency Home Response Service Install - FSS	☐	Service	5484	1.00	47.11	258351.24	
Emergency Home Response Service with Fall Detection	☒	Month	8418	6.94	43.58	2545983.69	
Emergency Home Response Service with Fall Detection - FFS	☐	Month	7530	6.94	43.58	2277412.36	

GRAND TOTAL: 4839651498.90

Total: Services included in capitation: 2929616252.90

Total: Services not included in capitation: 1910035246.00

Total Estimated Unduplicated Participants: 160164

Factor D (Divide total by number of participants): 30216.85

Services included in capitation: 18291.35

Services not included in capitation: 11925.50

Average Length of Stay on the Waiver: 287