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 with Disabilities waiver contains a few changes from the current waiver. The narrative below explains the primary differences.

1.Increased the Individual Provider (IP) and Respite Individual Provider rates. The rates will increase in the following manner effective July 1, 2026, with CMS approval, in response to the Service Employee International Union (SEIU) Collective Bargaining Agreement.

- Individual Provider and Respite Individual Provider increase from $19.50 to $20.00 an hour.
- Individual Provider (CNA) and Respite Individual Provider (CNA) increase from $22.50 to $23.00 an hour.
- Individual Provider (LPN) and Respite Individual Provider (LPN) increase from $29.50 to $30.00 an hour.
- Individual Provider (RN) and Respite Individual Provider (RN) increase from $36.25 to $36.75 an hour.

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 replace with the Dual Eligible Special Needs Plan program (D-SNP) model, which is called the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), which became effective 1/1/2026.

3. Edited Appendix B-2-a-Other to revise the service cost maximum (SCM) table to account for the 7/1/2026 rate increases. The new SCMs will be effective 7/1/2026, or upon CMS approval.

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

5. Edited Appendices C-2-d and C-2-e to remove language that prevented legally responsible individuals from working over 40 hours a week.

6. 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.

7. 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.

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

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

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 with Disabilities

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.0142
Waiver Number:IL.0142.R08.00
Draft ID: IL.018.08.00

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

Regular Waiver

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

07/01/26

Approved Effective Date: 07/01/26

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:

Persons with Disabilities

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of 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.

CMS approved Illinois' MLTSS 1915(b) waiver renewal on December 18, 2024 for a period of 5 years beginning January 1, 2025 through December 31, 2029.

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 effective date of May 1, 2011.

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

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

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Medicaid Home and Community-Based Services (HCBS) waiver for persons with disabilities was initially approved by the Centers for Medicare and Medicaid Services (CMS) in 1983. The Department of Human Services, Division of Rehabilitation Services (DHS-DRS) is the Operating Agency (OA). The Medicaid Agency (MA), the Department of Healthcare and Family Services (HFS) is the administering agency and has delegated the day-to-day operation of the waiver to DHS-DRS through an interagency agreement.

The HCBS waiver is part of a larger program called the Home Services Program (HSP). HSP operates under a state entitlement created as a result of a judicial decision emerging from the McMillan vs. McCrimon case in 1993. Under the entitlement, the program covers services for adults with non-exempt assets up to $17,500. Children under the age of 18 are covered if the family has no more than $35,000 in non-exempt assets. Those that do not meet Medicaid eligibility are funded with the state only monies. Customers may transition in and out of Medicaid eligibility. Services offered are the same for both Medicaid and state funded customers.

DHS, in its Division of Family and Community Services maintains Family and Community Resource Centers responsible for the determination of Medicaid eligibility. This responsibility is managed at these centers through a separate interagency agreement between DHS and HFS.

Customers must also meet the level of care need. A minimum score is required by a standardized assessment which includes a customer's mental status, and abilities to perform activities of daily living, and instrumental activities of daily living. Illinois utilizes currently the Illinois Determination of Need (DON) to determine eligibility. As the score on the DON increases, so too, does a customer's eligibility for increased service to meet their need. The administration of the DON, which establishes the level of care eligibility, is provided by HSP Rehabilitation Counselors from one of the statewide DHS-HSP offices.

For waiver customers not enrolled in a Managed Care Organization (MCO) the HSP offices within the OA are staffed with HSP Rehabilitation Counselors that serve as Care Coordinators. As stated, the HSP Rehabilitation Counselors determine HSP and waiver eligibility. They also engage the customer in the development of a Person Centered Plan (PCP) and work with the customer in monitoring the PCP. HSP Rehabilitation Counselors are state employees.

For customers enrolled in an MCO, after the HSP Rehabilitation Counselor determines level of care eligibility, Care Coordinators employed by the MCO chosen by the waiver customer engage the customer in the development of a PCP and work with the customer in monitoring the PCP.

HSP offers a full array of services which include; Individual Providers (IPs) (personal care attendants, skilled professional nursing, certified nursing assistants, therapies (Non-Agency); homemaker (Agency), skilled professional nursing, certified nursing assistants, therapies (Agency); adult day service; emergency home response; respite; home delivered meals; environmental modifications, and assistive equipment.

HSP is also a customer-directed program where most customers hire, supervise, and terminate their own caregivers (IPs) The program was designed as an independent living model; under the philosophy that regardless of disabilities or abilities, all customers have the right and responsibility to determine the direction of their lives, have full access to benefits of community living, the opportunity to receive services in the most integrated setting appropriate and to participate fully in life in a meaningful way. The OA acts as a joint employer and serves as the fiscal agent. This responsibility includes issuing payroll checks to IPs, withholding FICA and other deductions on behalf of the customer-directed IPs.

The OA works closely with the Illinois Centers for Independent Living (CILs). CILs are staffed by persons with disabilities, per Title VII of the Rehabilitation Act. There are CILs throughout the state that recruit and train IPs, provide training to waiver customers on how to manage workers and act as a resource to them.

Illinois mandatory managed care program, now called HealthChoice Illinois, operates statewide offering providers the opportunity to contract with MCOs in all Illinois counties. The Integrated Care Program (ICP), Family Health Plan/ACA Adults (FHP/ACA) and Managed Care Long Term Services and Supports (MLTSS) managed care programs are now incorporated in HealthChoice Illinois. Illinois' other managed care program, the Medicare-Medicaid Alignment Initiative (MMAI), ended December 31, 2025. On January 1, 2026, HFS implemented a Dual Eligible Special Needs Plan program (D-SNP). The D-SNP model available in Illinois is called the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). HFS is offering FIDE SNP because the Centers for Medicare and Medicaid Services (CMS) required states with an MMAI program to convert to a D-SNP model. The FIDE SNP program provides the same level of care coordination and integration of Medicare and Medicaid benefits included in the MMAI plans.

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:

On 3/13/2026, this proposed waiver renewal was shared with the tribal government and posted for public notice to the website of the Illinois Department of Healthcare and Family Services (HFS) at https://hfs.illinois.gov/info/legal/publicnotices.html; providing for a 30-day comment period ending 4/13/2026.

An electronic public notice is posted on the HFS website at https://hfs.illinois.gov/info/legal/publicnotices.html. A non-electronic public notice may be viewed at the Department of Human Services (DHS) local offices (except in Cook County). In Cook County, the notice may be reviewed at the Office of the Director, Illinois Department of Healthcare and Family Services, 401 South Clinton Street, 1st Floor, Chicago, Illinois.

A copy of the proposed waiver renewal may be downloaded and printed from the HFS website at https://hfs.illinois.gov/medicalclients/hcbs/disablities.html. A non-electronic copy of the proposed waiver renewal may be viewed at Department of Human Services (DHS) local offices throughout the state, except in Cook County. In Cook County, the proposed waiver renewal 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 hard copy of the proposed waiver renewal. The public notice invites comments via email or regular mail. Finally, the Illinois Department of Human Services, Division of Rehabilitation Services, the Operating Agency for the HCBS Waiver for Persons with Disabilities, emailed notification to its stakeholders and other interested parties of how to view and obtain a copy of the public notice and waiver renewal.

The State received one comment during the comment period.

1) Home Health Nurses do so much for families they work for. Sometimes they have to do things a person might not like doing like cleaning up messes that a client has made. With this in mind I encourage you to think about raising the wage to be more than fifty cents. Some have families of their own and need to make a livable wage. Sometimes Nurses have to work other jobs to make their life run smoothly. I would love for them to feel happy going to work most days.

State Response: Thank you much for your comments. We appreciate your input. We will be sure to share your suggestion with relevant internal team members.

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: Department of Healthcare and Family Services

Address: 201 South Grand Avenue East 2nd Floor

Address 2:

City: Springfield

State: **Illinois**

Zip: 62763

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

Fax: (217) 557-2780

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: Molly

First Name: Chapman

Title: Assistant Bureau Chief, Home Services Program

Agency: Illinois Department of Human Services, Division of Rehabilitation Services

Address: 100 S Grand Ave East 1st floor

Address 2:

City: Springfield

State: **Illinois**

Zip: 62763

Phone: (217) 836-4031 **Ext:** ☐ **TTY**

Fax: (217) 557-0142

E-mail: molly.chapman@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: Pam Winsel

State Medicaid Director or Designee

Submission Date: Jun 29, 2026

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-3-C:

For customers enrolled in an MCO, all grievances shall be registered with the MCO. The MCO's procedures must: (i) be submitted to the MA in writing and approved in writing by the MA (MCO Contract Section 5.30.1.1); (ii) provide for prompt resolution, (MCO Contract Section 5.30.1.2) and (iii) assure the participation of individuals with authority have no previous involvement of review, and provide appropriate clinical expertise to require corrective action (MCO Contract Section 5.30.1.4) . The MCO must have a Grievance Committee for reviewing grievances registered by its customers (MCO Contract Section 5.40.6). MCO customers must be represented on the Grievance Committee.

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

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

-The Grievance Committee must have at least one (1) customer on the Committee.
-A summary of all Grievances heard by the Grievance Committee, as well as 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. The state has provided that managed care 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. MCO also discuss the grievance and appeals process with the customer during the person-centered planning process.

CONTINUED FROM APPENDIX I-1
The results of all financial reviews are presented to OA personnel under cover memos with supporting claim detail. The OA will advise the MA of corrective actions taken, including adjustments, for all service claims identified by the reviews that were not paid in accordance with defined parameters. The FFP claims submitted to the Medicaid agency are verified by cross-referencing multiple databases to ensure the provider and customer are eligible at the time of service, among others. Claims which do not meet the criteria needed for acceptance are reported back to the operating agency for audit and review. The FFP claims audit and review process includes over 20 different audit reports to ensure inappropriate billings are not claimed. For each audit report, claims are analyzed in detail to determine if the claims are legitimate or if the transactions need to be corrected. For example, one of the audit reports lists claims that are potentially duplicate transactions. Each claim on the audit report is compared to transactions in the financial and case management systems to determine if the claims are unique or duplicate.

Analysis of FFP claims is conducted daily. The FFP manager works with the Illinois Department of Innovation & Technology (DoIT) and the Illinois Department of Healthcare and Family Services (HFS) to ensure all transactions in the systems are correct. Each week, the FFP manager provides a list of claims that require further action to appropriate staff. Transactions are either corrected within the system or deleted from the list of FFP claims.

The MA and OA 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.

For customers enrolled in a Managed Care Organization (MCO), the MA's internal and external auditing procedures will ensure that payments are made to a only 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. The MCOs 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.

CONTINUED FROM APPENDIX I-2-a

PERS rates include a one-time installation fee and a separate monthly rate for ongoing monitoring services. The rate covers maintaining adequate local staffing levels of personnel, installation, training, signal monitoring, and technical support and repairs. Rates are not geographically based and do not include room and board. PERS rates are reviewed minimally every five years by IDoA to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. The PERS rates were set in 2019 following a rate study completed in 2018. The IDoA worked with an external vendor to perform a rate comparison of Medicaid PERS in other states. It was determined that Illinois' installation rate was below the Medicaid reimbursement levels established in other states. The PERS rates were last reviewed in 2025.
The PERS installation, effective 07/01/2026, is $40.00.
The PERS monthly rate, effective 07/01/2026, is $28.00
The method of rate determination does not differ between self-directed services or services that are provider managed. Rate increases are consistently applied to both self-directed services or services that are provider managed.

Home Delivered Meals (HDM):
The home-delivered meal rate is standardized and are based on rates set under Title III of the Older Americans Act. The administrative rule specifies that the cost of HDM can be no more than what it would cost for an IP to prepare the meal. The rates are not geographically based and do not include direct or indirect administrative costs. The rate is subject to COLA when enacted and published on the OA's website under HSP. The HDM rate was last reviewed in 2025. The HDM rate will be reviewed minimally every five years.
The HDM rate, effective 07/01/2026, is $16.00 a day.

Respite:
Respite rates are based on the established rate for each service provider type. Rates are published on the OA's website under HSP. Rates are not geographically based and do not include room and board. The method of rate determination does not differ between self-directed services or services that are provider managed. Rate increases are consistently applied to both elf-directed services or services that are provider managed.

Environmental Accessibility Adaptations and Specialized Medical Equipment and Supplies:
Payments are subject to prior approval by the OA and MCO. For any item costing more than $5,000, two bids are required, and the lowest bidder is selected. If the lowest bidder cannot provide timely services, the next lowest bid may be selected. If two bids cannot be obtained or a bid is the sole source for lack of available vendors, a formal justification as to why two bids were not secured is required. Rate maximums, above which supervisory approval and written justification is required, are published on the OA's website under HSP. Purchases cannot exceed $26,300 every 3 years as identified in 89 Ill. Adm. Code 686.705 (c) and 89 Ill. Code 686.705(d).

Appendix A: Waiver Administration and Operation

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

   ○ **The waiver is operated by the state Medicaid agency.**

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The Illinois Department of Human Services, Division of Rehabilitation Services

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

Healthcare and Family Services (HFS) as the Medicaid Agency (MA) maintains an interagency agreement with the Illinois Department of Human Services, Division of Rehabilitation Services (DHS-DRS) as the Operating Agency (OA), which outlines the HCBS waiver responsibilities of both agencies. The OA is responsible for customer eligibility, Person Centered Plan (PCP) development, Home Services Program (HSP) budgeting, enrolling waiver providers, assuring PCP 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 Medical Policy Review Committee reviews all waiver rule and policy changes.

The MA meets at least quarterly with the OA and Managed Care Organizations (MCOs) to review program administration and evaluate system performance. The MA conducts routine oversight monitoring of the fiscal and program activities to assure that the State meets the federal assurances identified in the waiver.

There are two broad types of program reviews: record reviews and onsite comprehensive provider 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 onsite provider reviews are more comprehensive than the record reviews. The onsite reviews assess how the waiver program operates overall by reviewing components of customer eligibility; PCPs; provider qualifications; health, welfare, and safety; care coordination and how the system operates and communicates customer needs and issues.

For waiver customers not enrolled in managed care, the MA contracts with a Quality Improvement Organization (QIO) to provide quality oversight and monitoring of the waiver providers through audits that include record reviews of the customer's PCPs and the OAs activities of monitoring quality of services and supports that are provided to a customer participating in the HCBS waiver program. For waiver customers enrolled in MCOs, the MA and the state's External Quality Review Organization (EQRO) provide quality oversight and monitoring of the waiver providers through audits that include record reviews of the customer's PCPs and each MCO's activities of monitoring quality of services and supports that are provided to the MCO's customer participating in the HCBS waiver program. In addition, the QIO evaluates compliance with waiver performance measures. The EQRO include in their record reviews an evaluation of compliance with waiver performance measures and certain components of their contracts related to the waivers. The tool used by both to evaluate the waiver assurances include:

Level of Care-customer records are examined to determine completeness and accuracy of Determination of Need (DON) completed by the OA and the documentation supports LOC determination. The MCOs are required to obtain the score of the current DON completed by the OA.

Qualified Providers-the QIO and EQRO ensure an evaluation of the Individual Provider (IP) performance is completed annually, or according to the waiver requirements. Customer records are examined to determine the IP evaluation is completed.

The EQRO provides additional oversight of the MCOs by reviewing initial Care Coordinator qualifications and training, annual training, and oversight of caseloads.

Person Centered Plan (PCP) Development-customer records are examined to determine that all assessed customer needs, goals, and risks are addressed in a PCP; services are provided according to the PCP including engagement of the customer in the development of his/her PCP, goals are set and progress towards goals is indicated; PCP are signed and dated by the customer and the HSP Rehabilitation Counselors or MCO Care Coordinators validating inclusion and agreement; customers are routinely contacted by the HSP Rehabilitation Counselors and MCO Care Coordinators 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 examined to determine that customers are aware of how and to whom to report abuse, neglect, and exploitation; and each customer with an Individual Provider (IP) has a backup plan.

Oversight of the management of critical incidents (CI) and processes is the responsibility of the MA and the OA. The OA monitors CIs through a monthly report and presents a quarterly summary report of CIs during the quarterly quality management meeting with the MA. MCOs submit a detailed monthly report and a quarterly summary report of CIs to the MA. As part of the review and monitoring of compliance processes, the OA and EQRO reviews the policies and procedures for each HSP office and MCO for reporting CIs. OA staff and the EQRO review a sample of CI reports to ensure resolution and risk mitigation has occurred.

Remediation-the QIO and EQRO submits a report of findings to the MA, OA, and MCOs at the conclusion of each onsite review. The report consists of a summary of findings for each customer record reviewed, and a summary of overall findings detailed by performance measure and contractual requirements reviewed.

Remediation activities are tracked by the MA, OA, and EQRO to ensure 100% remediation of findings. Timeframes for completion of remediation are reported in 30, 60, 90, or greater than 90 days. Remediation activities are to be consistent with the approved activities detailed within each performance measure. The MA, OA, and EQRO work collaboratively to follow-up with the OA offices and MCOs to ensure remediation occurs within the required time frames.

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

MCOs are required to submit quarterly reports, using the format required by the MA, on specific performance measures, and as described in the MA's contracts with the MCOs. For each performance measure, contracts specify numerators, denominators, sampling approaches, and data sources among its requirements. MCOs present the results to the MA in quarterly meetings.

MCO contracts require remediation including corrective action plans and sanctions for failure to meet requirements for submissions of quality and performance measures.

Appendix A: Waiver Administration and Operation

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

- ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

  Illinois' mandatory managed care program, now called HealthChoice Illinois, began operating statewide effective January 1, 2018, offering providers the opportunity to contract with Managed Care Organizations (MCOs) in all Illinois counties; additional MCOs are available only to Cook County customers. The Integrated Care Program (ICP), Family Health Plan/ACA Adults (FHP/ACA) and Managed Long Term Services and Supports (MLTSS) managed care programs are now incorporated in HealthChoice Illinois.
  Customers enrolled in the FIDE SNP are not impacted by HealthChoice Illinois. For those waiver customers enrolled in a MCO, the MCOs will be responsible for care coordination, Person Centered Plan oversight, customer safeguards, prior authorization of waiver services, and quality assurance and quality improvement activities.
- ○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

- ◉ **Not applicable**
- ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
  Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

In the MA's contracts with Managed Care Organizations (MCOs) that provide waiver services, an External Quality Review Organization (EQRO) is responsible for MCO record reviews, and a Quality Improvement Organization (QIO) is responsible for fee-for-service record reviews.

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

The EQRO and QIO submit quarterly reports on specific performance measures described to the MA. For each performance measure, contracts specify required elements and format such as the numerators, denominators, sampling approaches, and data sources. When there are findings, remediation is required according to the parameters in the individual performance measure, including corrective action plans and sanctions for MCO failure to meet requirements for submissions of quality and performance measures.

The EQRO and QIO perform quarterly onsite audits of the Person Centered Plan (PCP) through record reviews. Upon completion of record reviews, a customer specific summary of findings, by measure, and a waiver specific summary report of findings and recommendations as appropriate is submitted to the MA. 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 MA, EQRO, and QIO work collaboratively to ensure remediation occurs within the required time frames. The MA also reviews for outliers and poor performing measures.

Appendix A: Waiver Administration and Operation

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

The State's Quality Improvement System (QIS) assures that the OA and Managed Care Organizations (MCOs) are complying with the federal assurances and performance measures that fall under the functions delegated to them by the Medicaid Agency (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 Operating Agency (OA) and the MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA pulls the sample annually and will adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

Once the MA selects the sample, it is provided to the QIO and to the EQRO. Quarterly onsite reviews are conducted at the MCOs by the EQRO. Annual onsite reviews and comprehensive provider reviews are conducted by the QIO at OA offices statewide. EQRO report of findings is sent to the MA and MCO. QIO report of findings is sent to the MA, OA, and OA office. Remediation is required within required timelines.

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

The MA meets quarterly with the MCOs and OA to assess compliance with the waiver assurances and to identify and analyze trends based on scope and severity. Remediation activities are reviewed and system 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	☑	☑	☐

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

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

Log of Substantive Changes

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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: Total number of QMC meetings where OA quality performance data was reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Agency Meeting Log

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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:
Medicaid Agency Meeting Log

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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 participants compared to the approved waiver capacity. N: Total number of active waiver participants 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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A5: Number and percent of interviewed waiver customers who indicate Adult Day Service settings optimize independence in making life choices. N: Number of interviewed waiver customers who indicate Adult Day Service settings optimize independence in making life choices. D: Total number of interviewed customers receiving Adult Day Service services.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A6: Number and percent of OA and MCO person centered plans signed by the customer that provided choice in receiving services at the setting. N: Number of OA and MCO person centered plans signed by the customer that provided choice in receiving services at the setting. D: Total number of person centered plans reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

The Medicaid Agency (MA), conducts routine programmatic and fiscal monitoring for both the Operating Agency (OA) and the Managed Care Organizations (MCOs). As part of this programmatic oversight of the OA and MCOs, the MA holds routine quarterly quality management meetings. During these meetings, the MA has a standing agenda that elicits feedback on the status of the performance measures and policy and program updates from the OA and MCOs. The MA monitors compliance with performance measures and timeliness of remediation. Quality improvement strategies are also discussed.

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, which are specified in the State's contracts with MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the External Quality Review Organization (EQRO), the MA monitors both compliance of

performance measures and timeliness of remediation for those waiver customers enrolled in an MCO through customer surveys and quarterly record reviews. Customers in MCOs are included in the representative sampling. Many of the performance measures are reported on and discussed during the quarterly Quality Management Committee meetings. During these meetings, the responsible entity will share results and all parties will discuss remediation and quality improvement strategies.

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 done within 30 days, the OA reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

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

A3: The MA will require completion of overdue reports. The MCO will submit a plan of correction 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: The provider is notified of interview responses. The provider requires all customers be provided required support in making life choices and documents in case file at facility.

A6: The provider is notified of Person Centered Plans (PCP) that do not indicate customer choice in selecting setting services. Require setting to update PCP to indicate customer choice in selecting setting services.

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**			☐
	☑	**Disabled (Physical)**	0	59	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Medical determination of a diagnosed, severe disability, which is expected to last for 12 months or for the duration of life.

Other criteria include:
1. Be a U.S. citizen or legal alien.
2. Be under age 60 at time of application.
3. Be a resident of the State of Illinois.
4. Be Medicaid eligible.
5. Be at risk of nursing facility placement, as measured by the Determination of Need (DON) assessment.
6. Enrolled in one waiver, the waiver that most appropriately meets his or her needs.
7. Ability to be maintained safely in the home at a service cost which does not exceed that of institutional 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:

The customer must be under the age of 60 at the time of application. After the age of 60, a customer may remain in the waiver as long as the customer was assessed prior to his/her 60th birthday. The customer then has the choice to stay in the Persons with Disabilities waiver or to transfer into the Persons who are Elderly (age 60 or older) waiver operated by the Illinois Department on Aging.

In addition, at any reassessment/redetermination of need, and depending upon the circumstances of the customer, it may be determined that the customer is best served by one of the other state waiver programs. For example, if the customer's condition is such that he/she seems appropriate for the State's HIV/AIDs waiver or Brain Injury waiver, the customer is referred and can be assessed for that program. If the customer is found eligible, the customer is subsequently provided with an informed choice between the waivers and of services and service providers. A Person Centered Plan (PCP) is then developed. Recognizing that no one waiver customer can be in two waivers at the same time, and the customer continues to meet eligibility requirements, the state assures through its policies and procedures that a smooth and seamless transition occurs with no breaks in service.

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 done in 1983. A revalidation conducted in the 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).

Analyses also identified ranges of DON scores, and associated Service Cost Maximum levels (SCM). These ranges were reflective of the severity of impairment and the customer's unmet needs. Analysis determined the level of funding required for each range of DON score, again depending upon level of impairment and need for service, similar to the case mix system in nursing facilities. Respective SCMs were correlated with similar expenditures at or below those for nursing home placement and assigned by scoring ranges.

The 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:

Below are Determination of Need scores and associated Service Cost Maximums (SCM) effective 7/1/2026, or upon CMS approval. SCMs may be updated in the future, based on increases in provider rates or other factors that impact the cost of waiver services.

DON score	SCM
29-32	$2,917
33-40	$3,347
41-49	$3,721
50-59	$4,447
60-69	$5,225
70-79	$5,645
80-100	$6,069

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:

Customer cost limits (service cost maximum-SCM) correspond with scores on the Determination of Need (DON) which identifies a customer's identified needs and existing supports. Eligibility is determined by meeting the minimum State established Level of Care. The range of scores and corresponding SCM is indicated under B-2 a. This amount directly corresponds to the amount the State would expect to pay for the nursing care component of institutionalization if the customer chose institutionalization.

The ranges were determined via research that was conducted by the University of Illinois Chicago, School of Public Health. The purpose of the study was to verify that the DON scoring corresponded with impairment and need. The SCMs were developed by determining institutional costs incurred by customers with similar DON scores. Although traditionally the Operating Agency (OA) costs are significantly below corresponding costs, they may not exceed the cost of institutionalization.

If a customer does not meet eligibility requirements as outlined in the 89 Illinois Administrative Code, Section 682, DRS sends the individual a Service Notice that informs the customer why he or she is not eligible. The notice also includes a statement that if the customer does not agree with this planned action, that customer can appeal the planned action. The notice explains how to appeal with the appropriate forms enclosed. The Rights and Responsibilities document explains that all services which were in effect at the time of the appeal will continue until the decision of the appeal is issued. Section F-1 describes the Fair Hearing Process in more detail.

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:

The SCM for a customer may be exceeded on a monthly basis to meet a temporary increase in need for services, as long as the average monthly cost for services during the twelve-month period does not exceed the SCM. Such an increase in services shall not last more than 3 months.

If a customer does not meet eligibility requirements as outlined in the 89 Illinois Administrative Code, Section 682, DRS sends the customer a Service Notice that informs the customer why he or she is not eligible. The notice also includes a statement that if the customer does not agree with this planned action, that individual can appeal the planned action. The notice explains how to appeal with the appropriate forms enclosed. The Rights and Responsibilities document explains that all services which were in effect at the time of the appeal will continue until the decision of the appeal is issued.

In addition to the Determination of Need (DON), DRS also uses a more comprehensive needs assessment that addresses multiple areas of needs, including non-waiver services. A complete narrative statement about the customer accompanies this assessment. The HSP offices utilize various community resources to assist the customer to access services needed that are not covered under the waiver.

If a customer has complex medical needs that cannot be served within the allowable SCM, the HSP Counselor may request an exceptional care rate (ECR). The ECR is established by the Department of Healthcare and Family Services (HFS) by multiplying the daily rate for the nearest licensed exceptional care nursing facility to the individual's home by 31 to establish a monthly maximum. This rate is comparable to the assessed cost for an institutional level of care and shall not be exceeded.

SCM for a case is exceeded due to a DHS-DRS approved provider rate increase, the customer may continue to receive the same amount of services, even though the SCM will be exceeded.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	38886
Year 2	41283
Year 3	43830
Year 4	46534
Year 5	49404

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. Customers that meet eligibility requirements are enrolled in the waiver upon completion of the waiver application. There is no waiting list for services. Initial waiver eligibility will be conducted by State-employed counselors as designated in the existing waiver and be based on the same objective criteria as for all. Selection of entrants does not violate the requirement that otherwise eligible individuals have comparable access to all services offered in the waiver.

For those customers who are enrolled in a Managed Care Organization (MCO), State-established policies governing the selection of customers for entrance to the waiver will remain the same as for all customers. Initial waiver eligibility will be conducted by State-employed counselors as designated in the existing waiver and be based on the same objective criteria as for all. Selection of entrants does not violate the requirement that otherwise eligible individuals have comparable access to all services offered in the waiver.

Appendix B: Participant Access and Eligibility

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

Waiver Phase-In/Phase-Out Schedule
Based on Waiver Proposed Effective Date: 07/01/26

a. The waiver is being (select one):

- (•) **Phased-in**
- ( ) **Phased-out**

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

Beginning (base) number of Participants: 32310

Phase-In/Phase-Out Schedule

Waiver Year 1
Unduplicated Number of Participants: 38886

Month	Base Number of Participants	Change	Participant Limit
Jul	32310	161	32471
Aug	32471	163	32634
Sep	32634	163	32797
Oct	32797	164	32961
Nov	32961	165	33126
Dec	33126	166	33292
Jan	33292	166	33458
Feb	33458	167	33625
Mar	33625	168	33793
Apr	33793	169	33962
May	33962	169	34131
Jun	34131	170	34301

Waiver Year 2
Unduplicated Number of Participants: 41283

Month	Base Number of Participants	Change	Participant Limit
Jul	34301	172	34473
Aug	34473	173	34646
Sep	34646	174	34820
Oct	34820	175	34995
Nov	34995	175	35170
Dec	35170	176	35346
Jan	35346	177	35523
Feb	35523	177	35700
Mar	35700	178	35878
Apr	35878	179	36057
May	36057	180	36237
Jun	36237	181	36418

Phase-In/Phase-Out Schedule

Waiver Year 3

Month	Base Number of Participants	Change	Participant Limit
Jul	36418	182	36600
Aug	36600	183	36783
Sep	36783	184	36967
Oct	36967	185	37152
Nov	37152	186	37338
Dec	37338	187	37525
Jan	37525	187	37712
Feb	37712	188	37900
Mar	37900	189	38089
Apr	38089	190	38279
May	38279	192	38471
Jun	38471	193	38664

Waiver Year 4

Unduplicated Number of Participants: 46534

Month	Base Number of Participants	Change	Participant Limit
Jul	38664	193	38857
Aug	38857	194	39051
Sep	39051	195	39246
Oct	39246	197	39443
Nov	39443	197	39640
Dec	39640	198	39838
Jan	39838	199	40037
Feb	40037	201	40238
Mar	40238	201	40439
Apr	40439	202	40641
May	40641	204	40845
Jun	40845	204	41049

Waiver Year 5

Unduplicated Number of Participants: 49404

Month	Base Number of Participants	Change	Participant Limit
Jul	41049	205	41254
Aug	41254	207	41461
Sep	41461	207	41668
Oct	41668	209	41877
Nov	41877	209	42086
Dec	42086	210	42296
Jan	42296	212	42508
Feb	42508	212	42720
Mar	42720	214	42934
Apr	42934	214	43148
May	43148	216	43364
Jun	43364	217	43581

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

Year One	Year Two	Year Three	Year Four	Year Five
☑	☑	☑	☑	☑

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	Jul	
Phase-in/Phase-out begins	Jul	1

	Month	Waiver Year
Phase-in/Phase-out ends	Jun	5

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ○ **Section 1634 State**
- ○ **SSI Criteria State**
- ● **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ● **No**
- ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR § 435.217)

- ☑ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- ☑ **Pregnant Women (42 CFR § 435.116)**
- ☑ **Infants and Children under Age 19 (42 CFR § 435.118)**
- ☐ **SSI recipients**
- ☑ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- ☑ **Optional state supplement recipients**
- ☑ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

  Specify percentage: [ ]

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)**
- ☑ **Medically needy in 209(b) States (42 CFR § 435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**
- ☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

The following groups are also included:

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

2) Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets pertaining to Title IV-E children under Section 1902(a)(10)(A)(i)(IX) of the Act and Section 42 CFR 435.150 of the federal regulations.

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

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

  Select one and complete Appendix B-5.

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

    Check each that applies:

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

      Select one:

      - ○ **300% of the SSI Federal Benefit Rate (FBR)**
      - ○ **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

        Specify percentage:
      - ○ **A dollar amount which is lower than 300%.**

        Specify dollar amount:
    - ☑ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**
    - ☐ **Medically needy without 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 customers equals the maximum income a customer can have and be eligible under 435.217 group.

- ( ) **The following dollar amount**

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

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

  Specify:

- ( ) **Other**

Specify:

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

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

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

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

    Specify:

  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - ( ) **The following dollar amount:**

    Specify dollar amount: If this amount changes, this item will be revised.
  - ( ) **The amount is determined using the following formula:**

    Specify:

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

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

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

  Specify:

Other
Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

The maintenance allowance for the waiver customers equals the maximum income 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:

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

Persons performing level of care evaluations must be an HSP Rehabilitation Counselor employed by the State of Illinois. Qualifications are a Master's Degree with major course work in rehabilitation, counseling, guidance psychology, or a closely related field.

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 standardized screening tool used for assessment is the Determination of Need (DON).

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

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 standardized screening tool used for level of care evaluation and reevaluation is the Determination of Need (DON). HSP Rehabilitation Counselors conduct the DON. The DON measures both ADL and IADL.

The re-evaluation process does not differ from the evaluation process. For customers enrolled in a Managed Care Organization, the initial level of care evaluation and re-evaluations are conducted by the OA.

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

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

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

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

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

The OA utilizes WebCM as a computer system that produces several reports including:

1) a "To Do" list that gives HSP Rehabilitation Counselors a 30-day advance notice of upcoming redeterminations for both fee-for-service and managed care customers and 2) a list of HSP Rehabilitation Counselors that are not completing redeterminations within the required timeframes. A post-review is also completed during monitoring visits conducted by both the OA and the Medicaid Agency (MA).

For customers enrolled in an MCO, the OA will employ procedures to ensure its timely redeterminations of level of care.

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

Records of initial determination and redetermination are maintained in the OA's WebCM virtual case management system as well as in each customer's hard copy case file. Each hard copy case file is maintained in the DHS-DRS local office associated with the customer's case. After a case is closed and the requisite two-year period has transpired, appropriate hard copy customer cases may be prepared for transfer to the OA's central storage location in Springfield, Illinois. Records in Springfield are maintained until they have met all appropriate guidelines for storage. Staff may request records from the Springfield location when necessary. The electronic version maintained in WebCM is retained indefinitely.

Records are kept by the MCO in their databases and case management systems and are made available to HFS for inspection, audit, and reproduction. Records will be maintained as required by 45 CFR §74.

Should the contract with HFS end, MCOs must maintain those records for a period of three (3) years from the date of final payment.

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: Eligibility Report (WebCM)

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **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 levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

Performance Measure:
B2: Number and percent of OA and MCO customers reassessed, as specified in the approved waiver, through the redetermination process of waiver eligibility every 12 months. N: Number of OA and MCO customers reassessed, as specified in the approved waiver, through the redetermination process of waiver eligibility every 12 months. D: Total number of OA and MCO customers who had reassessment due.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
B3: Number and percent of LOC determinations and reevaluations completed for OA and MCO customers using the processes and instruments described in the approved waiver. N: Number of LOC determinations and reevaluations completed for OA and MCO customers using the processes and instruments described in the approved waiver. D: Total number of LOC determinations and reevaluations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews, On-Site

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 WebCM data system has built-in edits to reject any assessments that do not meet the level of care criteria for the Determination of Need. It also has built-in reports to determine when redeterminations are due or overdue. The built-in edits are ongoing. The reports may be run as often as needed.

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

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

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS'

contracts with the MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the External Quality Review Organization (EQRO), the MA monitors both compliance of PMs and timeliness of remediation for those waiver customers enrolled in an MCO through consumer surveys and quarterly record reviews. Customers in MCOs are included in the representative sampling.

The OA will submit a quarterly report to the MA for PMs B1 and B2. Data for PM B3 will be gathered during on-site record review and reported to the MA quarterly.

b. Methods for Remediation/Fixing Individual Problems

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

B1: 1. LOC is done/corrected upon discovery; 2. If eligible, no additional action; 3. If ineligible, correction of billing and claims; 4. Individual staff training as appropriate. Remediation must be completed within 60 days.

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

B3: If it is discovered that the DON scores do not support LOC determination, the OA will require a plan of correction to include a reassessment or justification if in error. If the justification is inadequate and/or the reassessment does not result in the required scoring, the waiver eligibility will be discontinued, and the OA will assist the customer with accessing other supports and services. Federal claims will be adjusted, and the OA will provide technical assistance or training to HSP Rehabilitation Counselor. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- ◉ **No**
- ○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

HSP Rehabilitation Counselors inform customers of the feasible alternatives available under the waiver and outside of the waiver at the time they apply for services, and during each subsequent redetermination. The Application and Redetermination of Eligibility document and the Appeal Fact Sheet are given to each customer at initial assessment, and at subsequent annual redeterminations.

The Application and Redetermination of Eligibility form contains information regarding the Home Services Program's eligibility requirements and services. The Appeals Fact Sheet contains information regarding the customer's rights to appeal any case decision. The information is reviewed and explained with the customer at initial assessment and during each redetermination. The design of the Application and Redetermination of Eligibility form require customers to initial each section of the document to reflect an understanding of the material provided prior to a formal signature. Subsequent presentation of this information is noted in the customer's case file following each redetermination.

Customer preference is verified when the Person-Centered Plan is signed by the customer. By signing this form, customers acknowledge that they have been given a choice between home care and institutional/nursing facility care, are choosing to remain in the home, and agree that the services described in the service plan will assist them in remaining there.

For customers enrolled in an MCO, preference for institutional or home and community-based services will be documented on a Freedom of Choice form completed during the redetermination process. The customer must sign the completed form indicating his/her choice and that he/she has made an informed decision. MCO customers also sign off that choice was given between services and providers in their person-centered plan.

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

Customers sign person centered plans at each redetermination and reassessment and verify that they choose to receive waiver services as an alternative to institutional care. OA closed files are retained for a total of seven (7) years. Files are kept on site at the local HSP office for two (2) years and then transferred to the State Records Center in Springfield, Illinois for five (5) years at which time it will be disposed of, providing all audits have been completed and under the supervision of the Auditor General, and no litigation is pending or anticipated.

For customers enrolled in an MCO, the MCO will maintain the forms for a minimum of ten years from the final date of the contract period or from the date of completion of any audit, whichever is later. 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 entities under contract with the OA serve as access points and are integrated into the communities. In some areas, the HSP Rehabilitation Counselors interact on a daily basis with a wide variety of individuals with varying backgrounds, cultures, and languages. The HSP Rehabilitation Counselors have resources available to communicate effectively with individuals of limited English profiency in their community, including bilingual staff as needed, interpreters, and translated forms. Interpreter services are provided at no cost to customers.

For customers enrolled in an MCO, the MCO shall make all 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 MCOs' 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	**Homemaker**		
Statutory Service	**Individual Provider**		
Statutory Service	**Respite**		
Extended State Plan Service	**Home Health Aide**		
Extended State Plan Service	**Occupational Therapy**		
Extended State Plan Service	**Physical Therapy**		
Extended State Plan Service	**Speech Therapy**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Home Delivered Meals**		
Other Service	**In-Home Shift Nursing**		
Other Service	**Intermittent Nursing**		
Other Service	**Personal Emergency Response System**		
Other Service	**Specialized Medical Equipment**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04060 adult day services (social model)
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 in a non-institutional, 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.

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. Meals provided as part of these services may not constitute a "full nutritional regimen" (i.e., up to 2 meals per day and which do not constitute a full nutritional regimen is permitted).

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. Transportation between the participant's place of residence and the ADS is provided as a component of adult day services. 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 included in and 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
Agency	Adult Day Transportation

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):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 IL Admin Code 686.100

The ADS provider must meet staffing requirements, be compliant with applicable laws and codes, and successfully complete an Adult Day Care Compliance Review by DRS.

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment, every two years thereafter, and at time of IMPACT revalidation.

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 Transportation

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 IL Admin Code 686.100

The ADS provider must meet staffing requirements, be compliant with applicable laws and codes, and successfully complete an Adult Day Care Compliance Review by DRS.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment, every two years thereafter, and at time of IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
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):*

Homemaker is defined as general, non-medical support by supervised homecare aides who receive specialized training in the provision of services. The purpose of providing homemaker 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 duties 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 agency 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.

This service 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.

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Homemaker

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Adm. code 686.200

Agency qualifications include:
Compliance with all Medicaid provider requirements for the Illinois Department of Healthcare and Family Services (HFS) and DRS and successfully complete a Homemaker Compliance Review.
Provide DRS with a letter certifying compliance with applicable laws and codes and a copy of the Affirmative Action Plan for the Homemaker Service Provider.

Homemaker qualifications include:
1. Been determined to be in good health;
2. Knowledge and skill equivalent to a high school diploma;
3. Experience as a homemaker, either in his or her own home or through employment; and
4. Knowledge of nursing care; first aid, personal and environmental hygiene, household budgeting, housekeeping; nutrition, food preparation, and clothing care.

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment, every two years thereafter, and at time of IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Individual Provider

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
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):*

Individual Providers (IP) are non-agency based personnel that provide personal care services. An IP can also be a Personal Assistant (PA), CNA, LPN, or RN.

Personal care services includes a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance

(actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis.

All IPs are hired independently and supervised by the customer.

The IP assist with performing ADLs (bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities, e.g., personal hygiene, light housework, laundry, meal preparation, grocery shopping, using the telephone, medication and money management). IPs are not allowed to transport customers. Customers may have an IP and a homemaker. Tasks are separated on the Person Centered Plan and the OA monitors for duplication of services and payment.

The amount, frequency, and duration of services is based on the determination of need assessment conducted by the HSP Counselor and the service cost maximum determined by the DON score. Individual Provider services cannot be duplicative of services offered under EPSDT.

IP requirements are checked annually at the time of redeterminations to ensure they continue to meet waiver requirements.

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

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

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual Provider

Provider Category:

Individual

Provider Type:

Individual Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 IL Adm. Code 686.10

In order to be employed by a customer as an Individual Provider (IP) an employment certificate and meet all other requirements of the Child Labor Law, and will be supervised by an adult 21 years or older; 2) be 16 to 18 years of age and enrolled in school (must not be employed during school hours); 3) be 17 to 18 years of age and not enrolled in school; or 4) be an adult, 18 years of age or older.

The individual must have a Social Security number and provide HSP documentation of this number. The individual must have provided the customer with at least two written or verbal recommendations from present or former employers, a recommendation from a Center for Independent Living (CIL), or, if never employed, references from at least two non-relatives. The individual must be able to communicate with the customer and follow directions to the satisfaction of the customer and counselor. The individual must have previous experience and/or training that is adequate and consistent with the specific tasks required for safe and adequate care of the customer and if the customer has a contagious infectious disease, have a physician, health care institution (i.e., hospital, nursing home, home health agency), or CIL certify, in writing, that he/she has the knowledge of precautionary procedures for the control of contagious infectious diseases, if it is anticipated that he/she will come into contact with bodily fluids, or be evaluated by a licensed Registered Nurse to determine that he/she has knowledge of those procedures. The individual must complete all relevant forms required to work as an Individual Provider under the Home Services Program, some of which also require the customer's signature. The individual shall provide services to the customer in accordance with the Customer's Person Centered Plan and he/she shall comply with the Program's policies and procedures related to the Electronic Visit Verification system and the Home Services Program Overtime Policy. The individual shall submit bi-monthly Time sheets listing actual hours worked each pay period, which is verified by the customer and in accordance with the hours authorized on the Customer's Person Centered Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Customer with assistance from HSP Rehabilitation Counselor and MCO Care Coordinator. DRS and HFS also verify during monitoring.

Frequency of Verification:

At time of initial employment, during annual evaluations conducted by the customer, and at IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
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):*

Respite services are available to customers who are unable to care for themselves and are furnished on a short-term basis due to the absence or need for relief of those persons who normally provide care for the customer. Services are limited to individual providers, homemaker, nurses, and/or adult day service, and are provided to a customer to provide assistance with his or her activities of daily living during the periods of time when it is necessary for the family or primary care giver to be absent. Respite may be provided in the customer's home or in an adult day service setting.

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

By definition, Respite services are provided for no more than 240 hours per year. This can be used for 10, 24-hour days or the hours can be spread out throughout the year. HSP Respite is provided only in the home with the exception of Adult Day Service which can serve as one of the Respite services. Nothing remotely institutional is allowed to be used for Respite Services. The IT payment system has edits on what services may be provided in Respite, tracks the number of Respite hours provided by participant calendar year, and will not allow more than 240 hours to be billed during that time period.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [ ] **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	LPN
Agency	Home Health Agency
Agency	Adult Day Service
Individual	Home Health Aide
Agency	Homemaker
Individual	RN
Individual	Individual Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

LPN

Provider Qualifications

License *(specify):*

Illinois Nurse Practice Act - 225 ILCS 65

Graduation from an approved practical nursing program.
Obtain licensure through the Illinois Department of Financial and Professional Regulation.
Complete 20 hours of continuing education every 2 years.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and with IMPACT revalidation.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55

The Illinois Department of Public Health (IDPH) is the primary regulatory body responsible for licensing, inspections, and enforcement of standards for these agencies (210 ILCS 55/2.01).

Agencies must comply with rules regarding:
Licensure and provisional licenses
Staff qualifications and training
Infection control and safety
Client service contracts
Reporting abuse, neglect, or financial exploitation
Quality improvement programs

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Day Service

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Admin. code 686.100

The ADS provider must meet staffing requirements, be compliant with applicable laws and codes, and successfully complete an Adult Day Care Provider Review by DRS.

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment, every two years thereafter, and at time of IMPACT revalidation.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Home Health Aide

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

210 ILCS 45/3-206
The services are provided by an individual that meets Illinois standards for a Certified Nursing Assistant (CNA) through completion of an approved course. The CNA must provide a copy of the certificate of completion or be listed on the Illinois Department of Public Health Registry website.

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Homemaker

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Admin. code 686.200

Homemaker qualifications include:
1. Been determined to be in good health;
2. Knowledge and skill equivalent to a high school diploma;
3. Experience as a homemaker, either in his or her own home or through employment; and
4. Knowledge of nursing care; first aid, personal and environmental hygiene, household budgeting, housekeeping; nutrition, food preparation, and clothing care.

Homemaker Agency
A Homemaker Service Provider must be in compliance with all Medicaid provider requirements for the Illinois Department of Healthcare and Family Services (HFS) and DRS, and complete Homemaker Compliance Review.
the Homemaker Service Provider shall provide HSP with a letter certifying compliance with the provisions of the laws listed in subsection (f)(1) and a copy of the Affirmative Action Plan for the Homemaker Service Provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment, every two years thereafter, and at time of IMPACT revalidation.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

RN

Provider Qualifications

License *(specify):*

Illinois Nurse Practice Act - 225 ILCS 65

Graduation from an accredited associate (ADN) or baccalaureate (BSN) nursing program.
Obtain licensure through the Illinois Department of Financial and Professional Regulation.
Complete 20 hours of continuing education every 2 years.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individual Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 IL Adm. Code 686.10

In order to be employed by a customer as an Individual Provider (IP) an employment certificate and meet all other requirements of the Child Labor Law, and will be supervised by an adult 21 years or older; 2) be 16 to 18 years of age and enrolled in school (must not be employed during school hours); 3) be 17 to 18 years of age and not enrolled in school; or 4) be an adult, 18 years of age or older.

The individual must have a Social Security number and provide HSP documentation of this number. The individual must have provided the customer with at least two written or verbal recommendations from present or former employers, a recommendation from a Center for Independent Living (CIL), or, if never employed, references from at least two non-relatives. The individual must be able to communicate with the customer and follow directions to the satisfaction of the customer and counselor. The individual must have previous experience and/or training that is adequate and consistent with the specific tasks required for safe and adequate care of the customer and if the customer has a contagious infectious disease, have a physician, health care institution (i.e., hospital, nursing home, home health agency), or CIL certify, in writing, that he/she has the knowledge of precautionary procedures for the control of contagious infectious diseases, if it is anticipated that he/she will come into contact with bodily fluids, or be evaluated by a licensed Registered Nurse to determine that he/she has knowledge of those procedures. The individual must complete all relevant forms required to work as an Individual Provider under the Home Services Program, some of which also require the customer's signature. The individual shall provide services to the customer in accordance with the Customer's Person Centered Plan and he/she shall comply with the Program's policies and procedures related to the Electronic Visit Verification system and the Home Services Program Overtime Policy. The individual shall submit bi-monthly Time sheets listing actual hours worked each pay period, which is verified by the customer and in accordance with the hours authorized on the Customer's Person Centered Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Customer with assistance from HSP Rehabilitation Counselor and MCO Care Coordinator. DRS and HFS also verify during monitoring.

Frequency of Verification:

At time of initial employment, during annual evaluations conducted by the customer, and at IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Home Health Aide

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08020 home health aide
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):*

Extended State Plan Service - Home Health Aide are part of the treatment plan outlined by the attending physician. These services include the use of simple procedures as an extension of therapeutic services; ambulation and exercise; personal care; household services essential to healthcare at home; assistance with medications that are ordinarily self-administered; and reporting changes in a customer's condition and needs to the registered nurse or appropriate therapist.

The provided services are as defined in 42 CFR 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid state plan shall not be applicable.

All medically necessary services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [ ] **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Home Health Aide
Agency	Home Health Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Home Health Aide

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

210 ILCS 45/3-206
The services are provided by an individual that meets Illinois standards for a Certified Nursing Assistant (CNA) through completion of an approved course. The CNA must provide a copy of the certificate of completion or be listed on the Illinois Department of Public Health Registry website.

Individuals seeking employment must:
Be at least 16 years old, of temperate habits, and possess good moral character, being honest, reliable, and trustworthy.
Be able to speak and understand English or a language understood by a substantial percentage of the facility's residents.
Provide evidence of employment or residence for the two years prior to current employment.
Have completed at least 8 years of grade school or provide proof of equivalent knowledge.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At the time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55

The Illinois Department of Public Health (IDPH) is the primary regulatory body responsible for licensing, inspections, and enforcement of standards for these agencies (210 ILCS 55/2.01).

Agencies must comply with rules regarding:
Licensure and provisional licenses
Staff qualifications and training
Infection control and safety
Client service contracts
Reporting abuse, neglect, or financial exploitation
Quality improvement programs

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At the time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
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):*

Extended State Plan Service - Occupational Therapy is a medically prescribed service identified in the Person Centered Plan that is designed to increase independent functioning through adaptation of the tasks and environment. The service is provided by a licensed occupational therapist that meets Illinois licensure standards. Occupational therapy through the waiver focuses on long-term habilitative needs rather than short-term acute restorative needs.

Services may be approved under the waiver if the individual is no longer eligible for therapies under the state plan, but continues to need long-term habilitative services.

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's Person Centered Plan. The amount, duration, and scope of services is based on the Determination of Need assessment conducted by the HSP Rehabilitation Counselor and the service cost maximum determined by the DON score.

Services provided through the state plan are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan, the first 60 days following discharge from a hospital or long term care facility do not require prior approval when services are initiated within 14 days of discharge. Services may be provided under the waiver when the individual does not meet eligibility requirements for the state plan services.

All medically necessary occupational therapy services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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	Home Health Agency
Individual	Occupational Therapist

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55

The Illinois Department of Public Health (IDPH) is the primary regulatory body responsible for licensing, inspections, and enforcement of standards for these agencies (210 ILCS 55/2.01).

Agencies must comply with rules regarding:
Licensure and provisional licenses

Staff qualifications and training
Infection control and safety
Client service contracts
Reporting abuse, neglect, or financial exploitation
Quality improvement programs

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

225 ILCS 75
Graduation from an accredited program.
Hold a current licensure through the Illinois Department of Financial and Professional Regulation.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11090 physical therapy
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):*

Extended State Plan Service - Physical Therapy is a medically prescribed service identified in the service plan that utilizes a variety of methods to enhance an individual's physical strength, agility and physical capacities for activities of daily living. The service is provided by a licensed physical therapist that meets Illinois licensure standards.

Physical therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs. Physical therapy can be used to train IPs to perform exercises and/or maintenance activities within the customers home.

Services may be approved under the waiver if the individual is no longer eligible for therapies under the state plan, but continues to need long-term habilitative services.

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the Determination of Need assessment conducted by the HSP Rehabilitation Counselor and the service cost maximum determined by the DON score.

Services provided through the state plan are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan, the first 60 days following discharge from a hospital or long term care facility do not require prior approval when services are initiated within 14 days of discharge. Services may be provided under the waiver when the individual does not meet eligibility requirements for the state plan services.

All medically necessary physical therapy services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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	Home Health Agency
Individual	Physical Therapist

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55

The Illinois Department of Public Health (IDPH) is the primary regulatory body responsible for licensing, inspections, and enforcement of standards for these agencies (210 ILCS 55/2.01).

Agencies must comply with rules regarding:
Licensure and provisional licenses
Staff qualifications and training
Infection control and safety
Client service contracts
Reporting abuse, neglect, or financial exploitation
Quality improvement programs

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

225 ILCS 90
Graduation from an accredited program.
Hold a current licensure through the Illinois Department of Financial and Professional Regulation.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy

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):*

Extended State Plan Service - Speech Therapy is a medically prescribed speech and/or language based service identified in the Person Centered Plan that is used to evaluate and/or improve a customer's ability to communicate. The service is provided by a licensed speech therapist that meets Illinois licensure standards. Speech therapy through the waiver focuses on long-term habilitation needs rather than short-term acute restorative needs.

Services may be approved under the waiver if the individual is no longer eligible for therapies under the state plan, but continues to need long-term habilitative services.

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's Person Centered Plan.

The amount, duration, and scope of services is based on the Determination of Need assessment conducted by the HSP Rehabilitation Counselor and the service cost maximum determined by the DON score.

Services provided through the State plan are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long-term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan, the first 60 days following discharge from a hospital or long-term care facility do not require prior approval when services are initiated within 14 days of discharge. Services may be provided under the waiver when the individual does not meet eligibility requirements for the State plan services.

All medically necessary speech therapy services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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	Home Health Agency
Individual	Speech Therapist

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55

The Illinois Department of Public Health (IDPH) is the primary regulatory body responsible for licensing, inspections, and enforcement of standards for these agencies (210 ILCS 55/2.01).

Agencies must comply with rules regarding:
Licensure and provisional licenses
Staff qualifications and training
Infection control and safety
Client service contracts
Reporting abuse, neglect, or financial exploitation
Quality improvement programs

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Speech Therapist

Provider Qualifications

License *(specify):*

Speech and Language Pathologists are licensed pursuant to the requirements in (225 ILCS 110/) Illinois Speech-Language Pathology and Audiology Practice Act.
Master's or doctoral degree from a program approved by the Illinois Department of Financial and Professional Regulation.
Hold a current licensure through the Illinois Department of Financial and Professional Regulation.
Passage of the PRAXIS examination or certification from the American Speech-Language-Hearing Association or from the American Board of Audiology.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
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):*

Those physical adaptations to the home, required by the individual's Person-Centered Plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, generators, modifications, room additions, increased square footage of living space, increased total square footage of the home, etc. All services shall be provided in accordance with applicable State or local building codes.

Home modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Environmental Modification Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Environmental Modification Contractor

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Adm. code 686.600
Must be an enrolled Medicaid provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Prior to project initiation and at time of IMPACT enrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
06 Home Delivered Meals	06010 home delivered meals
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):*

Prepared food brought to the customer's residence that may consist of a heated luncheon meal and a dinner meal (or both) which can be refrigerated and eaten later. Frozen meals may be authorized if preferred by the customer. This service is designed primarily for the customer who cannot prepare his/her own meals but is able to feed him/herself. This service will be provided as described in the Person-Centered Plan and will not duplicate those services provided by personal care services or homemaker provider. Meals provided shall not constitute a full nutrition regimen and are limited to no more than the equivalent of 2 meals/day. The frozen meal is a statewide option, replacing the heated luncheon and dinner meals. The customer will choose a vendor that will deliver either fresh heated meals or frozen meals to their home. If the vendor supplies both fresh heated meals and frozen meals, the customer may have a choice as to the type of meal delivered each day. The person-centered plan of care will indicate meal preference. HSP Counselor will inform customers on the benefits of meal type including nutritional values, authorize the service and document the conversation. Vendors, including all food preparation facility locations, are required to be certified by local public health entities as well as meet minimum industry standards necessary to sell the product. Bulk delivery is prohibited outside of inclement weather, rural residency and weekend delivers. Standard delivery schedule will include a maximum of 7 days' worth of meals to occur on a weekly basis. The amount, duration, and scope of services is based on the determination of need assessment conducted by the HSP counselor or case manager 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	Home Delivered Meals Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

By Health Department where vendor is located

Other Standard *(specify):*

89 Il. Adm. Code 686.500
The Home Delivered Meal provider must be certified by the health department in the county in which the program or facility is located and must meet the approval of the customer.

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

DRS obtains a copy of the HDM agency's Public Health certificate on an annual basis to verify that the provider meets state and local health codes, at at IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

In-Home Shift Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
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 shift nursing is the provision of nursing services on a continuous basis. In-home shift nursing is different than intermittent nursing, where nursing services are provided on a periodic or intermittent basis to perform a specific task.

These services are provided by registered nurses (RNs) and licensed practical nurses (LPNs) that meet Illinois licensure standards. RNs and LPNs may only provide services authorized through their licensure type. Services may include the following:

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

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

All medically necessary nursing services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

The Person Centered Plan includes the type of service(s) to be provided to the customer, the specific tasks involved, the frequency with which the specific tasks are to be provided, the number of hours each task is to be provided per month, and the rate of payment for the service(s).

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	Home Health Agency
Individual	LPN
Individual	Registered Nurse

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

ILCS 55

The Illinois Department of Public Health (IDPH) is the primary regulatory body responsible for licensing, inspections, and enforcement of standards for these agencies (210 ILCS 55/2.01).

Agencies must comply with rules regarding:
Licensure and provisional licenses
Staff qualifications and training
Infection control and safety
Client service contracts
Reporting abuse, neglect, or financial exploitation
Quality improvement programs

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

LPN

Provider Qualifications

License *(specify):*

225 ILCS 65, the Illinois Nurse Practice Act.
Graduation from an approved practical nursing program.
Obtain licensure through the Illinois Department of Financial and Professional Regulation.
Complete 20 hours of continuing education every 2 years.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

225 ILCS 65, the Illinois Nurse Practice Act.
Graduation from an accredited associate (ADN) or baccalaureate (BSN) nursing program.
Obtain licensure through the Illinois Department of Financial and Professional Regulation.
Complete 20 hours of continuing education every 2 years.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Intermittent Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
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):*

Intermittent Nursing services are provided within the scope of the State's Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the state and are not otherwise covered through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

Intermittent nursing is used for purposes of evaluating customer needs (including assessments and wellness checks) and monitoring.

Intermittent nursing is paid in two-hour increments and is different from other waiver nursing services that are paid hourly. Hourly nursing services are for ongoing and routine care needs.

The amount, duration, and scope of services is based on the determination of need assessment conducted by the HSP Rehabilitation Counselor/MCO Care Coordinator and the service cost maximum determined by the DON score.

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's Person Centered Plan. The Person Centered Plan includes the type of service(s) to be provided to the customer, the specific tasks involved, the frequency with which the specific tasks are to be provided, the number of hours each task is to be provided per month, and the rate of payment for the service(s). Each type of nursing is a specific service with specific codes.

Services provided through the state plan are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan, the first 60 days following discharge from the hospital or long term care facility do not require prior approval when services are initiated within 14 days of discharge. Services may be provided under the waiver when the individual does not meet eligibility requirements for the state plan services.

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

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

☑ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse
Agency	Home Health Agency
Individual	LPN

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intermittent Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

225 ILCS 65 Illinois Nurse Practice Act
Graduation from an accredited associate (ADN) or baccalaureate (BSN) nursing program.
Obtain licensure through the Illinois Department of Financial and Professional Regulation.
Complete 20 hours of continuing education every 2 years.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intermittent Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

ILCS 55

The Illinois Department of Public Health (IDPH) is the primary regulatory body responsible for licensing, inspections, and enforcement of standards for these agencies (210 ILCS 55/2.01).

Agencies must comply with rules regarding:
Licensure and provisional licenses
Staff qualifications and training
Infection control and safety
Client service contracts
Reporting abuse, neglect, or financial exploitation
Quality improvement programs

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intermittent Nursing

Provider Category:

Individual

Provider Type:

LPN

Provider Qualifications

License *(specify):*

225 ILCS 65 Illinois Nurse Practice Act
Graduation from an approved practical nursing program.
Obtain licensure through the Illinois Department of Financial and Professional Regulation.
Complete 20 hours of continuing education every 2 years.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and at IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
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):*

Personal Emergency Response System (PERS) is an electronic device that enables certain customers to secure help in an emergency. The customer may also wear a portable "help" button to allow for mobility. The system is connected to the customer's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff

the response center. PERS services are limited to those customers who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. This service has two components: an initial installation fee and a monthly service fee.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Emergency Home Response

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Adm. code 686.300
In order to be a DHS approved EHRS Provider, the EHRS Provider must:
a) have trained employees or volunteers that install the EHRS units in the individual's home. This service may not be sub-contracted;
b) be able to install the EHRS unit in the individual's home within 48 hours upon referral of an individual by DHS to the EHRS provider;
c) assist the individual in arranging several appropriate responders and provide training to those responders;
d) provide 24-hour monitoring;
e) provide instruction to the individual receiving EHRS services on the proper use of the EHRS unit at the time the unit is installed. The instruction must include:
1) provisions for monthly testing of the unit and its transmission by the individual receiving the EHRS services; and
2) general care of the home unit; and
f) in the event of unit malfunction, the EHRS Provider must repair or replace the unit within 24 hours of receiving the report.

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and IMPACT revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
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):*

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the Person Centered Plan, which enable customers to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items, which are not of direct medical or remedial benefit to the customer. All items shall meet applicable standards of manufacture, design and installation.

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

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	Pharmacies
Agency	Medical Suppliers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Pharmacies

Provider Qualifications

License *(specify):*

225 ILCS 85
Hold a current licensure through the Illinois Department of Financial and Professional Regulation.
Required to deliver; install; provide maintenance, replacement, or instruction in use of medical equipment for home-based care.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must maintain at least $500,000 in liability insurance. A copy of the insurance certificate is obtained by the HSP Counselor and maintained in the customer's case file. Within 30 calendar days of customer's receipt of equipment, the counselor must make a home visit to verify that the equipment has been delivered to the customer or repaired, and to ensure customer satisfaction. Written verification from the customer shall be required to verify receipt and satisfaction.

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and IMPACT revalidation.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Medical Suppliers

Provider Qualifications

License *(specify):*

225 ILCS 51
Hold a current licensure through the Illinois Department of Financial and Professional Regulation.
Required to deliver; install; provide maintenance, replacement, or instruction in use of medical equipment for home-based care.

Certificate *(specify):*

N/A

Other Standard *(specify):*

68 Il. Adm. Code 1253
Providers must maintain at least $500,000 in liability insurance. A copy of the insurance certificate is obtained by case manager and maintained in customer's case file. Within 30 days of customer's receipt of equipment, the counselor must make a home visit to verify that the equipment has been delivered to the customer or repaired, and to ensure customer satisfaction. Written verification from the customer shall be required to verify receipt and satisfaction.

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and IMPACT revalidation.

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:

The Illinois Department of Human Services operates the Home Service Program (HSP) though local offices across the state, staffed with HSP Rehabilitation Counselors that directly oversee the care provided to persons with disabilities under this program. The HSP Rehabilitation Counselors are state employees.

For customers enrolled in a Managed Care Organization (MCO), care coordination will be the responsibility of the MCO.

HSP Rehabilitation Counselors, MCO Care Coordinators and service providers have both initial and ongoing training requirements in the contract and/or rate agreement with their agency. Workers who have become inactivated would need to meet the criteria to be re-enrolled and would require retraining upon becoming re-enrolled.

Case Management Services are claimed pursuant to Part 3 - Section 2 of the Public Assistance Cost Allocation Plan (PACAP). The total cost is in accordance with the approved cost allocation plan. Desk and field audits are performed as internal controls to ensure compliance with PACAP requirements.

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):

The Medicaid Agency (MA) initiated a provider enrollment system in Fiscal Year 2016 in response to requirements of the Affordable Care Act. The Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system is a web-based system designed to improve provider access, and to ensure customers receive timely and high quality Medicaid services, including services provided to Medicaid waiver customers. Providers must be enrolled in the IMPACT system prior to being reimbursed for services. Background check are completed on each provider during the enrollment process. Information about all convictions is shared with the MA's Office of Inspector General (OIG) for review and follow-up. Certain felony convictions will prevent providers from being enrolled in the IMPACT system. The decision to reject an enrollment application on the basis of a felony conviction is determined by the OIG. Providers must meet all qualifications and pass all screening checks to be approved and entered in IMPACT. A provider cannot be enrolled and serve Medicaid customers unless all mandatory screenings have been conducted.

The Healthcare Worker Background Check Act (the Act) (225 ILCS 46) requires criminal background checks be completed through the Illinois State Police for direct service staff hired by specified health care employers in Illinois. The agencies include those providing home health, homemaker, or adult day services. The Act applies to all individuals employed or retained by the health care employer, where he/she provides direct care or has access to long-term care residents, their living quarters or their financial, medical, or personal records. These agencies may not knowingly hire or retain any person in a full-time, part-time or contractual direct service position if that person has been convicted of committing or attempting to commit one or more of the disqualifying convictions listed in the Act. The Act does not apply to individuals who are licensed by the Illinois Department of Financial and Professional Regulation or the Illinois Department of Public Health (DPH) under another law of the State, including Registered Professional Nurses (RN), Licensed Practical Nurses (LPN) or licensed therapists.

Individual Providers (IPs), hired independently by the customer, are excluded from the act due to a grass roots effort of the disability community to allow the exclusion. The State, however, offers customers the option to conduct the criminal background check without cost when hiring the IP if they so choose. The Operating Agency (OA) provides information to the customers on how to request a criminal background check. The results of the criminal background check are returned directly to the customer. The MA verifies criminal background checks for staff at homemaker and adult day service agencies during MA oversight monitoring reviews. For home health agencies, the DPH, as the licensing agency, verifies that home health agencies comply with the Act during licensure reviews.

IPs and licensed workers hired independently by the customer are not listed on the DPH Registry. However, if the person has a work history as a CNA or Developmental Disability (DD) Habilitation Aide, and if abuse, neglect or misappropriation of funds was substantiated while working in a long term care facility or DD funded agency, the information would remain open on the registry. Customers are offered the option to obtain a background check on the worker's name through "Mind Your Business". This offers customers the opportunity to make informed choices about the IPs they hire. This service is offered at no cost to the customer and background check results are sent directly to the customer. In addition, mandatory background screens on all providers are required by the Illinois Medicaid Program Cloud Technology (IMPACT) system. IMPACT is a provider enrollment system that was adopted in response to requirements under the Affordable Care Act and is maintained by the MA. The background screen reveals criminal convictions that may affect the provider's ability to be approved to work as an eligible Medicaid provider. Background screen "hits" are reported to the MA's OIG, which reviews the results and makes a final determination.

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):

The Illinois Department of Public Health (DPH) maintains the Health Care Worker Registry. Home health agencies must conduct screenings on all certified nursing assistants (CNA) prior to providing care. Registry checks are maintained in the employee's file. DPH verifies compliance for home health agencies during licensure reviews. The Medicaid Agency (MA) reviews files during monitoring reviews at home health agencies to assure documentation is present in the employee's file if the customer is being served by a CNA.

The registry includes certification status for CNA as well as history of substantiated abuse, neglect or exploitation while employed in a nursing facility. Employers also report on the results of criminal background checks to the registry, including disqualifying convictions. For more information on the Health Care Worker Registry see: http://www.idph.state.il.us/nar/home.htm .

Homemaker agencies and Individual Providers employed by customers are not currently required to conduct registry screenings. However, if the person has previously worked as a CNA and if abuse, neglect or misappropriation of funds was substantiated, the information would be on the registry. The Home Services Program Rehabilitation Counselors offers customers the option of completing a background check and provides information on how to conduct the registry checks. This would allow the customer the opportunity to screen the worker for history of abuse, neglect, or criminal conviction that would disqualified him/her from working in an institution or other health care position covered by the Healthcare Worker Background Check Act (225 ILCS 46).

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 legally responsible individual (LRI) is defined as a customer's spouse; a parent, stepparent or foster parent of a customer who is under age 18; or a legal guardian of a customer who is under age 18.

The LRI of a waiver customer is allowed to furnish personal care through individual provider services, to include assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) only when they meet the definition of extraordinary care. Prior to the legally responsible adult providing service, the HSP Rehabilitation Counselor or the MCOs Care Coordinator will discuss with the customer that there are no other viable service/provider alternatives and document this in the customer record. Extraordinary care is defined as care that exceeds the range of activities that the LRI would ordinarily perform in the household on behalf of the customer, if the customer did not have a disability or chronic illness, and that is necessary to ensure the health and welfare of the customer and avoid institutionalization. The LRI must meet all qualifications and possess the skill to provide the extraordinary care services to the customer and must meet all qualifications for enrollment as an Individual Provider, including IMPACT enrollment. Personal care services that meet the definition of extraordinary care include the following:
- Eating
- Bathing
- Grooming
- Dressing
- Transferring
- Incontinence Care
- Routine health
- Special health

The following safeguards will ensure that the services provided by the LRI meet the definition of extraordinary care and seek to identify and prevent instances of abuse, neglect, or fraud:
- WebCM or the MCOs electronic case management systems and Electronic Visit Verification records/timesheets will be used by OA and MCOs to track service provision and compare to extraordinary care hours authorized on the PCP.
- Unannounced in-person wellness checks will be conducted in the customer's home twice a year for all customers who have a LRI providing services. These visits, conducted by the OA or MCO, are in addition to the annual home visit.
- LRIs with history of abuse, neglect, or exploitation are not eligible.
- Customers and LRIs who have committed HSP or Medicaid fraud are not eligible.

The PCP will identify the tasks that meet the definition of extraordinary care and will detail the number of allowable hours per task. Customers with an LRI will be identified in WebCM and the electronic case management systems used by MCOs to alert staff of the relationship to the customer. LRIs are paid in accordance with the current effective bargaining agreement, like all other Individual Providers, but must not exceed the total allowable hours assigned to extraordinary care tasks. OA staff and MCO Care Coordinators will conduct a quarterly review of hours worked to the PCP to ensure appropriate utilization and management of LRI hours by the customer. Overages will be submitted to the HSP Fraud Unit and the customer may no longer be eligible to hire an LRI to provide extraordinary care services.

During the unannounced in-person wellness checks, annual home visits, and any additional in-home visits, the HSP Rehabilitation Counselor, OA Case Manager, or MCO Care Coordinator will assess the customer's general condition and home environment to ensure services are being provided in accordance with the customer's PCP and to ensure that payments are made only for services rendered. Attention will be paid to the customer's hygiene and cleanliness, nourishment status, noting any odors in the house, as well as the general cleanliness of the home, etc. If concerns are identified, the HSP Rehabilitation Counselor, OA Case Manager or MCO Care Coordinator will discuss the issues with the customer and the LRI. If concerns are not addressed to the satisfaction of the HSP Rehabilitation Counselor, OA Case Manager, or MCO Care Coordinator, the PCP could be changed to restrict the customer's ability to hire an LRI and/or require the inclusion of an agency-based provider.

HSP Rehabilitation Counselors and MCO care coordinators will collaborate to ensure policies that pertain to oversight of LRIs align. Monitoring of customer's management of the LRI's performance, delivery of service according to the PCP, and concerns related to the customer's well-being must be monitored consistently for all waiver customers.

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.*

A relative or legal guardian may provide Homemaker, Respite, Home Health Aide, Intermittent Nursing, Occupational Therapy, Physical Therapy, Speech Therapy, Environmental Accessibility Adaptations, or In-Home Shift Nursing. The Legally Responsible Individual may not.

The relative or legal guardian must meet all provider qualifications, including IMPACT enrollment. Relatives or legal guardians with history of abuse, neglect, or exploitation are not eligible, nor are those customers, relatives, or legal guardians who have committed Medicaid fraud or fraud against HSP.

HSP staff will review time sheets and payroll records to ensure the customer did not approve more hours per week than authorized. If a relative or legal guardian is found to have worked more than the authorized hours per week according to the person-centered plan (PCP), the case will be referred to the HSP Fraud Unit. If HSP can verify fraud, the case may result in criminal prosecution, the relative or legal guardian may be required to pay back any funds determined to be fraudulent, and the customer may no longer be eligible to hire a relative or legal guardian. The relative or legal guardian may also be determined permanently ineligible for future payments from the HSP. A customer that has committed HSP Fraud or Medicaid Fraud will not be approved to hire a relative or legal guardian. A relative or legal guardian that has committed abuse, neglect, exploitation, HSP fraud or Medicaid fraud cannot work for the customer.

Services provided by a relative will only be provided when it has been determined by the Home Services Program (HSP) Counselor or Managed Care Organization (MCO) care coordinator that the customer has the ability to supervise the relative. Services provided by a legal guardian must be supervised by an authorized representative

The OA and MCOs use a standard process for determining the customer's ability to self-direct. If the customer is unable to communicate or has cognitive or emotional limitations that negatively impact their communication or decision-making ability, the HSP Counselor or the MCO care coordinator may determine that the customer does not have the capacity to self-direct their services. This determination is typically supported from case documentation, which can be obtained from a number of sources, including but not limited to medical reports, psychological and neuropsychological evaluations, HSP Counselor, or the MCO care coordinator's observations, documented instances showing the inability to properly manage a relative , information from the customer's family and/or representative, and failure to pass the Mini-Mental Status Examination on the Determination of Need. If it is determined that a customer cannot self-direct, the HSP Counselor will assist the customer and their family in identifying a legal guardian, power of attorney, or other authorized representative to represent the customer and to assist with the determination and PCP development process in a way that honors the customer's known wishes, values, and preferences.

The MCOs have received training from the OA regarding customer direction and oversight of a relative or legal guardian. The OA has shared their provider standards with the MCOs that include information on how to determine if the relative or legal guardian can meet the customer's needs. The OA also provides guidance on how to determine when a relative or legal guardian is not meeting a customer's needs and when it is appropriate to change from an relative or legal guardian to an agency-based provider.

Generally, payment will not be made to a relative or legal guardian while the customer is hospitalized. A relative or legal guardian may currently deliver only those personal care services that the acute care hospital is unable to provide, and only if the participant has a Determination of Need (DON) score of 75 or higher. Any such services must already be included in the participant's plan of care. The number of hours and the cost of these services may not exceed what is authorized in the participant's current plan of care. Additionally, authorization to provide services in an acute care hospital setting must be obtained in advance from the HSP Counselor. If there is a hospital claim on the same day as a relative or legal guardian claim not preapproved per above, the claim will be reported to the HSP Fraud Unit. All relative or legal guardian provided services will be closely monitored for fraud and abuse. Relatives or legal guardians must be qualified to meet all Federal and State regulatory guidelines and must be hired by the customer. Timesheets for a relative are signed by the customer to verify that the services were rendered. If the customer is not able to verify time worked, or if a legal guardian is serving as the service provider, an authorized representative must sign the timesheets. For minor children whose parent or legal guardian is the provider, an authorized representative must sign the timesheets. A legal guardian is not authorized to verify and sign their own timesheets. Currently, the OA requires both paper timesheets and Electronic Visit Verification (EVV). The OA is working toward eliminating timesheets and using EVV only.

Customers have the authority to hire, fire, and direct provision of services of relatives. Customers with legal guardians working as service providers require a representative who can manage the legal guardian service provider and direct the provision of services. Relatives and legal guardians are reimbursed twice monthly and must complete and sign time sheets at the end of every pay period to indicate the days and hours worked. Customers verify the provision of services by signing the timesheets. By signing the timesheet, the customer acknowledges that services were provided by the relative or legal guardian as detailed on the timesheet and therefore authorizes payment for the services provided.

Verification of care may be determined from other sources as well. Family members, friends, neighbors, social workers, or other providers can serve as information sources concerning the customer's care. For example, the HSP Rehabilitation Counselor, the OA Case Manager or MCO Care Coordinator may receive a call from another family member who is concerned about a potential lack of care being provided to the customer.

The HSP Rehabilitation Counselor, OA Case Manager, or MCO Care Coordinator may follow up by conducting an unannounced home visit or may schedule a nursing evaluation. The HSP Rehabilitation Counselor, OA Case Manager, or MCO Care Coordinator also verifies that services are provided in accordance with the customer's PCP. During redeterminations assessments are made regarding the customer's general condition, hygiene and cleanliness, consideration is made regarding the customer's nourishment status, noting any odors in the house as well as the cleanliness of the home, etc. If discrepancies are identified, the HSP Rehabilitation Counselor, OA case Manager, or MCO Care Coordinator determines whether care is being provided at the appropriate level and in accordance with the PCP. Based upon these observations the HSP Rehabilitation Counselor, OA Case Manager or MCO Care Coordinator may follow up with an unannounced home visit, arrange for a nursing assessment to determine whether the customer is receiving the proper level of care, and if not, change the PCP to include an agency-based 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:

Over 85% of the providers in this program are Individual Providers (IPs) who are hired directly by the customer. Anyone that meets the IP requirements and is selected by the customer may become a provider. Customers hire, train, supervise and can terminate their IP workers. The customer is responsible for approving hours and work product of the IP before submission to the state for reimbursement. Providers of types of services such as homemaker and adult day service are obtained through an All Willing and Qualified Request for Qualifications process and can apply at any time. Eligible providers are approved and enrolled. Home health providers, such as nurses and therapists, must meet the individual licensing requirements under the Illinois Department of Financial and Professional Regulations (DFPR). The State Medicaid Agency (MA) enrolls all willing and qualified providers that are chosen for waiver services through the Illinois Medicaid Program Cloud Technology (IMPACT) system.

Illinois Centers for Independent Living (CIL) offer IP training programs. Some also maintain a list of trained providers, while others offer training to the customer on how to hire and manage the IP. All customers are given the name of the CILs in their area. This information is included as a component of the "customer's packet". It is made available to the customer at initial determination and will be provided subsequently if requested by the customer. The customer may contact the local CIL for a listing of potential IPs if they are not able to locate a provider on their own.

The Department of Human Services (DHS), as the Operating Agency (OA), uses any homemaker agency that meets enrollment requirements, and if enrolled must provide services within the scope of the Person Centered Plan (PCP) and authorized rate structure. Homemaker agencies may learn about working with the OA through the Illinois Home Care and Hospice Council (IHCC). This organization is a statewide, nonprofit, trade association that promotes the delivery of quality health care and supportive services in a variety of home living environments in the state of Illinois. Through the organization, homemaker agencies can learn of the potential of enrolling as a waiver provider with the OA and the MA to provide homemaker services to waiver customers. The Request for Qualifications is an ongoing opportunity for interested homemaker agencies to request an application for services. Eligible providers are approved and enrolled, if they meet required qualifications and are willing to accept the OA's authorized rate for services.

Adult Day Service providers enroll with the OA in the same manner as the homemaker agencies. The OA will enroll Adult Day Service agencies that have been approved to be providers by the Illinois Department on Aging.

Managed Care Organizations (MCOs) are required to offer contracts to all approved HCBS waiver providers in the MCO's contracting area. All MCOs provide statewide coverage health plans, with the exception of CountyCare, which covers Cook county, only. County Care must offer contracts to all providers in Cook county. Provider qualifications may be enhanced by the MCO.

In addition to the above, MCOs must continually meet the following network adequacy requirements throughout the term of their contracts.

For each of the following HCBS waiver services, MCOs must contract, on a county-by-county basis, with a network of providers that are currently serving in aggregate at least 80% of current customers in the fee-for-service system. In counties where there is more than one service provider, MCOs must contract with at least two providers, even if one provider serves more than 80% of current customers. In counties where there is no current service provider, MCOs must contract with the providers in other counties who, in the aggregate, currently provide at least 80% of the services to customers in that county.

Adult Day Service
Homemaker
Home Delivered Meals
Home Health Aides
Nursing Services
Occupational Therapy
Speech Therapy
Physical Therapy
Day Habilitation

The State determined the network adequacy requirements based on an analysis of the number of providers in each county and the percentage of current customers receiving services from each provider. The State determined that an 80% standard will require MCOs to contract with the majority of providers in a region and ensures a network with more than

adequate capacity to serve 100% of MCO customers. In addition, the State feels an 80% standard aligns with federal assumptions regarding the number of dual eligible customers who will opt out of the financial alignment demonstration. In the HealthChoice Illinois program, the 80% standard far exceeds the percentage of waiver customers enrolled in HealthChoice Illinois.

The following requirements apply for the remaining HCBS waiver services:

Environmental Modifications: MCOs will be monitored to ensure that provider meets the needs within 90 days.

Individual Provider (IP): The State is not dictating a network adequacy requirement, as IPs are hired at the discretion and choice of the customer. However, MCOs are required to assist customers in locating potential IPs as necessary. MCOs must refer customers to a CIL or other resources if the customer is in need of help locating a IP.

Personal Emergency Response System: MCOs must meet administrative code 240.235 with at least one provider serving each county within a contracting area.

All provider qualifications and requirements are found verbatim on the DHS Website, at http://www.dhs.state.il.us/page.aspx?item=27896 . The website includes links to provider enrollment instructions, licensure and certification requirements, instructions for becoming a provider, relevant administrative rules, and contact information.

The web link above contains information for providers for an array of DHS programs. Provider enrollment instructions are contained in the "IMPACT" link. There is also a "Become a Provider" link, and there are links for "Licensure and Certification" and for "Rules." Contact information is available in a link for "Rehabilitation Services Provider Information" under the "Provider Information by Division" heading.

For HealthChoice Illinois, MCOs shall enter into a contract with any willing and qualified provider in the contracting area that renders waiver services so long as the provider agrees to MCO's rate and adheres to MCO's quality requirements. To be considered a qualified provider, the provider must be in good standing with the MA's Fee for Service (FFS) Medical Program. MCO may establish quality standards in addition to those State and Federal requirements and contract only with providers that meet such standards. Such standards must be approved by the 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.

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.**

a) Individual Providers (IPs) may currently deliver only those personal care services that the acute care hospital is unable to provide, and only if the participant has a Determination of Need (DON) score of 75 or higher. Any such services must already be included in the participant's plan of care. The number of hours and the cost of these services may not exceed what is authorized in the participant's current plan of care.

b) For customers discharging from acute care hospitalization back into the community, DRS may complete a service plan addendum if there has been a change in the customer's condition such that an increase or decrease in hours, a change in the level of care, or the elimination of and/or addition of service(s) is indicated.

c) Individual Provider (IP) rates do not vary based on whether services are provided during the customer's stay in an acute care hospital setting.

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: # and % of newly enrolled lic/cert waiver providers who meet provider requirements and adhere to other standards in the approved waiver prior to providing waiver services. N: # of newly enrolled lic/cert waiver providers who meet provider requirements and adhere to other standards in the approved waiver prior to providing waiver services D: Total # of newly enrolled lic/cert waiver providers.

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

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

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

Data Aggregation and Analysis:

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

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:
C2: # & % of enrolled lic/cert waiver providers who continue to meet prov req and adhere to other standards in the approved waiver prior to continuing to provide waiver services.N: # of enrolled lic/cert waiver providers who continue to meet prov req and adhere to other standards in the approved waiver prior to continuing to provide waiver services. D: Total #of enrolled lic/cert waiver providers.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Source (Select one):

Other
If 'Other' is selected, specify:
HFS IMPACT System, Operating Agency

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
HFS IMPACT System and Operating Agency

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:

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

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

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

Performance Measure:
C5:#&% of OA HSP Rehab Counselors (RCs) and MCO Care Coordinators (CCs)

who meet training requirements in accordance with state requirements and the approved waiver prior to providing waiver services. N:# of OA HSP RCs and MCO CCs who meet training requirements in accordance with state requirements and the approved waiver prior to providing waiver services D:Total number of OA HSP RCs and MCO CCs.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:
HSP Training Reports and MCO Training 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:
C6: #&% of OA HSP Rehab Counselors and MCO Care Coordinators who continue to meet training requirements in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. N: # of OA HSP RCs &MCO CCs who continue to meet training reqs in accordance with state reqs &approved waiver prior to continuing to provide waiver svcs. D:Total # OA HSP RCs & MCO CCs

Data Source (Select one):
Other
If 'Other' is selected, specify:
HSP Training Reports and MCO Training 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:
C7: Number and percent of Individual Providers who received training in accordance with state requirements and the approved waiver. N: Number of Individual Providers who received training in accordance with state requirements and the approved

waiver. D: Total number of Individual Providers reviewed.

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

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

Data Aggregation and Analysis:

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

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

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

The Medicaid Agency(MA) will conduct routine programmatic and fiscal monitoring for both the Operating Agency (OA) and the Managed Care Organizations (MCOs).

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

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

The IMPACT system allows the MA to ensure 100% of licensed or certified providers continue to meet the required standards by performing automatic checks of the IL Department of Financial and Professional Regulation's licensure and certification database and exclusion databases. If a provider has a termination or lapse in licensure or certification or appears on an exclusion database, the MA will disenroll the provider and notify the OA. The waiver participant is notified, and a different provider is selected. To ensure an adequate network, both the MA and OA work with providers to correct any lapse in licensure or certification and to troubleshoot any issues with enrollment to regain approved provider status. Both the MA and OA monitors network capacity to ensure an adequate network.

Similarly, for non-licensed/non-certified providers the IMPACT system allows the MA to ensure 100% of providers continue to meet the required standards by performing automatic checks of the IL Department of Public Health's Healthcare Worker Registry and exclusion databases. If a provider has a disqualifying finding on the Healthcare Worker Registry or appears on an exclusion database, the provider is disenrolled and the information is shared with the OA. The waiver customer is notified, and a different provider is selected. To ensure an adequate network, both the MA and OA work with providers to correct any lapse in licensure or certification and to troubleshoot any issues with enrollment to regain approved provider status. Both the MA and OA monitors network capacity to ensure an adequate network.

For training, the MA will request reports from the OA and the MCOs to verify that Home Services Program Rehabilitation

Counselor and MCO Care Coordinators initially meet and continue to meet, provider training requirements. These reports will also be shared during the quarterly meetings.

b. Methods for Remediation/Fixing Individual Problems

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

C1: If services were provided by an unqualified provider, the Medicaid Agency (MA) would deny the claim and make the provider inactive. Additionally, the MA would identify vulnerabilities in the system and take appropriate action. Remediation is required within 30 days.

C2: If services were provided by an unqualified provider, the MA would deny the claim and make the provider inactive. Additionally, the MA would identify vulnerabilities in the system and take appropriate action. Remediation is required within 30 days.

C3: Provider will be notified by the Operating Agency (OA) of lacking documentation. Receipt of completed Individual Provider (IP) packet or disenroll would be required. Remediation is required within 30 days. If services were provided by an unqualified provider, the MA would deny the claim and make the provider inactive. Additionally, the MA would identify vulnerabilities in the system and take appropriate action. Remediation is required within 30 days.

C4: If services were provided by an unqualified provider, the MA would deny the claim and make the provider inactive. Additionally, the MA would identify vulnerabilities in the system and take appropriate action. Remediation is required within 30 days.

C5: A moratorium will be placed on assigning cases to until outstanding trainings are completed. Outstanding trainings will be completed within 60 days.

C6: A moratorium will be placed on assigning cases to until outstanding trainings are completed. Outstanding trainings will be completed within 60 days.

C7: The training requirements will be completed. Remediation within 60 days

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

  The total cost for purchase of all environmental modifications and assistive equipment purchase, rentals, and repairs shall not exceed $26,300 every 3 years as identified in 89 Ill. Adm. Code 686.605(c) and 89 Ill Adm. Code 686.705(d), increased from $25,000 every 5 years.

- [ ] **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.)*

Settings utilized for services are the customer home and non-residential provider settings for the provision of Adult Day Services. The adult day services are provided in an adult day services center. There are no residential settings in the waiver. These settings meet the federal HCB settings requirements at 42 §§ CFR 441.301(c)(4)-(5).

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Prior to enrollment as an OA-approved provider, the OA completes an initial on-site compliance review of all waiver settings to ensure compliance with all federal HCB Setting requirements. Then, once every two (2) years thereafter, as well as when needed in response to compliance concerns, the OA conducts an ongoing compliance review of all waiver settings to ensure continued compliance with all federal HCB Setting requirements. Both initial and ongoing compliance reviews consist of desk audits of provider-submitted policy, procedure and other documents reflecting compliance with OA program regulations and an on-site assessment. The OA reviews customer case files (including ensuring person-centered plans of care meet HCB Settings requirements), and a review of staff personnel records (including training information). In addition to visual observations, the OA conducts interviews with customers, provider administrators and supervisors, and direct care staff, to ensure provider compliance with all HCB Settings requirements. The OA utilizes a standardized review process and a review tool to ensure review completeness, and adherence to State and Federal regulations.

At initial and annual eligibility assessments, OA customers are provided with their HSP Rehabilitation Counselor's name and contact information. MCO case managers also provide their contact information to customers during annual service planning. Customers are educated on how to relay provider concerns to HSP Rehabilitation Counselors and MCO case managers during service planning and eligibility assessments. HSP Rehabilitation Counselors and MCO case managers are educated to relay provider complaints to their respective administrative offices.

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

In state fiscal year 2027, the MA will begin annual remote compliance reviews and select on-site compliance reviews of waiver settings to monitor OA oversight and provider compliance with all Federal HCBS Settings requirements. These reviews may include interviews with HCBS customers and direct HCBS provider staff. The MA will utilize a standardized review process and a review tool to ensure review completeness, and adherence to all HCB Settings criteria.

To monitor for ongoing compliance of settings requirements in customer's homes, the OA has processes are in place to support customer engagement in meaningful, goal-driven activities while promoting autonomy, independence, and informed decision-making. HSP Counselors and MCO Care Coordinators discuss freedom of choice of providers, review progress towards goals, physical health, emotional health, and social needs. This is validated through waiver performance measures, which includes reviewing the PCP to assure that services are based on customer needs, strengths, and preferences and that the PCP includes individual goals and supports needed to meet desired outcomes.

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

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:

Home Services Program (HSP)Rehabilitation Counselors are employed by the State of Illinois. Qualifications include:
a Master's Degree with major course work in rehabilitation, counseling, guidance, psychology, or a closely related field, plus one-year of professional experience.

For customers enrolled in an Managed Care Organization (MCO), qualifications for the Care Coordinators vary within each of the MCOs. Customer are assigned to specific Care Coordinators based on individual need and identified risk. At a minimum, qualifications include the following license or education level:
1) Registered Nurse (RN),
2) Licensed Clinical Social Worker (LCSW);
3) Licensed Marriage and Family Therapist (LMFT);
4) Licensed Clinical Professional Counselor (LCPC);
5) Licensed Professional Counselor (LPC);
6) PhD;
7) Doctorate in Psychology (PsyD);
8) Bachelor or Masters prepared in human services related field;
9) Licensed Practical Nurse (LPN)

The MCO Care Coordinators are required to complete 20 hours of training, initially and annually, as specified in the managed care contract. MCO care coordinators must be trained on on disability related subjects and issues.

☐ **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.

The Person-Centered Plan (PCP) begins with a customer centered assessment conducted by an HSP Rehabilitation Counselor or MCO Care Coordinator. Both utilize skills to engage customer to participate in and direct the PCP process. The development of these skills, and the approach to customer inclusion at all levels within the PCP development, requires on-going training and is a critical component during the hiring process and the ongoing supervision of staff.

All conversations between the HSP Rehabilitation Counselor or MCO Care Coordinator, and the customer, are customer focused and continuously reinforce that the PCP process is a collaborative effort, enabling the customer to lead the process to the best of their ability and that the PCP is owned and agreed to by the customer. The options discussed and the choices made are documented in the PCP. The PCP is written in plain language and in a manner understandable by the customer. The customer is provided the information by both the HSP Rehabilitation Counselor and MCO Care Coordinator that all persons identified by the customer may participate in the PCP process. The OA Home Care Consumer Bill of Rights, the HSP Application and Redetermination of Eligibility Agreement, and MCOs Customer Rights and Responsibilities documents are provided to each customer. These documents identify the right of the customer to choose all persons to be included in all PCP, and eligibility determination and redetermination meetings. The date, time, and setting for the meetings are set and every accommodation possible is made to include all persons identified by the customer. The customer is informed of the types of services provided under the waiver, as well as options of all willing and qualified providers. The customer and all providers must sign the PCP, and each are provided a copy.

The HSP Rehabilitation Counselor completes a Person-Centered Goal Addendum. The addendum incorporates the customer's strengths, capacities, needs, preferences, desired outcomes, personal goals, risks, and ways to mitigate/eliminate the risk, and reviews issues such as housing, employment, recreation, and emotional health. This addendum and the assessment are used to develop the PCP. This form states that the PCP is the result of conversations and assessments that address customer's needs using programs and services provided under the waiver and those outside the waiver. The MCO Care Coordinator complete an initial health risk assessment. The information gathered by both the HSP Rehabilitation Counselor and MCO Care Coordinator is used to work with the customer to develop a PCP to address the customer's needs, strengths, personal goals and desires, barriers to achieving these goals, and identify risks and implement strategies to minimize or eliminate them. Other components assessed are cognitive/emotional needs, activities of daily living (ADLs), instrumental activities of daily living (IADLs), behavioral health needs, medication, living supports, environmental conditions, and health care information. Reassessments are conducted annually and when a significant change occurs in the customer's condition.

MCO's are required to complete a face-to-face health risk assessment (HRA) within 90 days of enrollment and re-assess the PCP at least every 90 days, per the terms of their contract with the State. The contract also requires contact visits every 90 in the customer's home. Face-to-face health risk assessment occurs each time there is a significant change in the customer's condition or at the customer's request.

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

Both the HSP Rehabilitation Counselor and MCO Care Coordinators are also required to offer as much choice as possible with selecting providers to accommodate customer preferences and choice. Both use a rotation method to select agency providers and offer a contract to all willing and qualified waiver providers. By terms of their contract, the MCO must enter into contracts with a sufficient number of such providers within each county in the contracting area to assure that the affiliated providers served at least 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 provider of such covered services, the MCO shall enter into contracts with at least two such providers, so long as such providers accept MCOs rates, even if one served more than 80% of the customers, unless the MA grants the MCO an exception. The most commonly utilized waiver service is the Individual Provider (IP). Customers are supported in identifying, training, and supervising their IP(s). These processes and actions further demonstrate the lead role of the customer in PCP development and implementation.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A) Who develops the plan, who participates in the process and the timing of the plan;

OA Process:
The State is committed to implementation of a person-centered planning process as required by 42 CFR 441.301(C)(4)(5). Following determination of program eligibility, the HSP Rehabilitation Counselor and the customer discuss and schedule, usually by phone, the determination of eligibility and redeterminations. During this conversation, the time of the actual meeting(s) is scheduled at the convenience of the customer and other parties that the customer wishes to have included. The DON assessments are conducted remotely (telephone or video conferencing) unless the customer requests an in-person visit. All other face-to-face assessment visits are often conducted in the customer's residence as this is most convenient to the customer and leads to more accurate PCP development for the customer. Changes to location are to meet the customer's needs and are not for the convenience of HSP Rehabilitation Counselor.

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

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

OA Process:
Service needs are identified based on the Determination of Need (DON) assessment tool, which includes the Mini-Mental State Exam (MMSE). The DON evaluates the customer's level of impairment in activities of daily living and whether the customer's care needs are met by family members or other supports. The MMSE examines the customer's cognitive function. The HSP Counselors utilize medical records (latest History & Physical, hospital discharge paperwork, PT/OT notes, etc) to ensure they corroborate scoring on the DON. An HSP Counselor will not finalize a DON until supportive medical records are secured, unless it is a triage referral. They also complete a narrative as well as a needs assessment and a financial data sheet for customers. These tools are all used to develop/update the PCP.

The process in all assessments is to have the customer articulate his/her needs, goals, and desires. HSP Rehabilitation Counselors are trained to engage the customer to direct the PCP planning process as much as possible. Using this as a basis for a holistic approach to care coordination, the assessment of the customer's situation and circumstances identifies all factors contributing to quality of life and the customer's ability to live independently in the community. In addition, an addendum, is completed and incorporates the customer's strengths, capacities, needs, preferences, desired outcomes, personal goals, risks, and ways to mitigate/eliminate the risk, and reviews issues such as housing, employment, recreation, and emotional health. The addendum is part of the PCP.

MCO Process:
The MCOs have similar comprehensive assessment tools that contain components that are used to elicit a wide-range of information from the customers and their representatives to support PCP development. These components in the assessments include, but are not limited to cognitive/emotional, ADLs, IADLs, behavioral health, medication, living supports, environmental conditions, and health care information. The MCOs also review the DON, which identifies ADLs and IADLS and need for care which is conducted by the OA. The assessment secures information including the customer strengths, needs, levels of functioning, and risk factors. The MCOs also use the MCO claims data and real-time customer data to identify a customer's risk level and to help in the creation of the PCP. MCOs also use referrals, transition information, service authorizations, alerts, grievance system, memos, and other assessment tools adopted by the MA, and from families, caregivers, providers, community organizations, and MCO personnel. Through the assessment and PCP processes the customer's goals and the strengths and barriers to achieving these goals are identified. Again, the MCOs, like the HSP Rehabilitation Counselors, are trained to look at the individual and approach the customer to directing the process.

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

c) Informing customer of services available under the waiver.

OA Process:
As part of the determination of eligibility and redetermination process, the HSP Rehabilitation Counselor and customer discuss the array of services, regardless of funding sources, which are available to them and to which they are eligible. It is the HSP Rehabilitation Counselor's responsibility to explain all service options to the customer, including, but not limited to waiver services. HSP Rehabilitation Counselors are required complete training services that are available through other state and federal agencies, local entities, and charitable organizations. During these meetings, customers are informed of their rights. A document explaining the appeals process is given to customers at each PCP development, at the time of application, reassessment, and at any time a service is changed. HSP Rehabilitation Coordinators are encouraged to work out any customer concerns prior to filing an appeal.

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

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

OA Process:
The comprehensive assessment takes into consideration the customer's goals, desires, and other needs, including health care needs as described above in (b). Waiver services that are included in the PCP meet an unmet care need of the customer, and/or provide relief to the primary unpaid caregiver. Services should mitigate risk, be cost-effective, and be the most economical services available. The customer's PCP that results from the conversation between the customer and HSP Rehabilitation Counselor should be one in which the customer agrees. Subsequently, the customer and the HSP Rehabilitation Counselor approve and sign the PCP. In addition, the customer is given an informed choice of providers of waiver services and he/she has discretion in approving service providers, including the IP, if this service is identified in the PCP.

Part of this holistic approach to PCP development, includes a conversation regarding medical/health care needs. It is recognized looking at a systems approach, that unaddressed needs with physical health impact the delivery of long-term services and supports, as well as challenges and inconsistencies in the delivery of long-term services and supports impact health status. While the responsibility of coordination is on the customer, it is up to the HSP Rehabilitation Counselor to raise the critical issues and help the customer problem solve with all service needs.

MCO Process:
Comprehensive assessments are developed by each MCO. The MCO contract specifies expectations for waiver customers, including content of and purposes for PCP.
After the comprehensive assessment has been completed by the Care Coordinator, and the array of services have been presented to and discussed with the customer, the Care Coordinator, the customer and/or their representative(s) formulate a PCP that addresses their goals, strengths, and barriers/risks in consideration of these goals, and the mutually agreed upon activities for achievement of these goals. Personal preferences, such as cultural preferences and provider preferences for language and gender, are integral to 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.
The strength of the MCO model is the actual coordination of health care needs and long-term services and supports. MCOs develop a holistic PCP and are responsible for monitoring its implementation, along with the customer.
On behalf of the MA, the EQRO reviews the MCOs comprehensive assessments as part of its pre-implementation record review, onsite post-implementation record review, as well as in quarterly record reviews to make sure the

assessments meet contractual requirements.

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

OA Process:
A comprehensive determination of eligibility is completed at the initial assessment and at least annually thereafter. The PCP that is developed includes waiver and non-waiver services the customer is receiving, regardless of funding source. PCPs are shared with providers and they are trained to report any changes in the customer situation to the HSP Rehabilitation Counselor including a disruption of other, non-waiver services. Identifying all agencies in the home in the PCP assists the provider agencies to know who should be in the home and during what times, providing an additional level of quality assurance. Services are coordinated by the HSP Rehabilitation Counselor, who is responsible for the identification, authorization, and assignment to the responsible service provider in coordination with and direction from the customer and/or their representative.

MCO Process:
A comprehensive assessment is completed at the initial assessment and at least annually thereafter. The PCP that is developed includes waiver and non-waiver services the customer is receiving, regardless of funding source. PCPs are shared with providers, and they are trained to report any changes in the customer situation to the Care Coordinator including a disruption of other, non-waiver services. Identifying all agencies in the home in the PCP assists the provider agencies to know who should be in the home and during what times, providing an additional level of quality assurance.
Services are coordinated by the Care Coordinator, who is responsible for the identification, authorization, and assignment to the responsible service provider in coordination with and direction from the customer and/or their representative.

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

OA Process:
The OA mandates that upon initial determination of eligibility and every redetermination thereafter, the HSP Rehabilitation Counselor must provide the Customer's Bill of Rights to the customer. This document outlines the responsibility of the customer and the responsibilities of the MA and OA as it relates to receiving services. Included in these responsibilities of the customer is the responsibility to notify the HSP of any changes in their status, i.e., hospitalizations, changes in needs, changes in financial status, etc. The OA requires this document not only be given, but also explained and reviewed with the customer. Documentation in the customer's case record must support that this requirement was met. Provider agencies are directed to notify the HSP of changes in the customer's status. OA policies and training outline the responsibilities of the HSP Rehabilitation Counselor. These responsibilities include development and continual monitoring of the PCP.

MCO Process:
The MCO Care Coordinator is responsible for the execution of the PCP, which includes monitoring the provision of waiver services and risk mitigation strategies. The customer's role is clearly defined in the PCP, and the customer is responsible for actively participating and providing feedback. The Customer's Bill of Rights, as described above, is provided, explained and reviewed with the customers.
The MA mandates that upon initial assessment and every assessment thereafter, the Care Coordinator provides the rights and responsibilities brochure to the customer. These brochures outlines the responsibility of the customer and the responsibilities of the MA and MCO as it relates to services. Included in these responsibilities of the customer is the responsibility to notify the Care Coordinator of any changes in their status, i.e., hospitalizations, changes in needs, changes in financial status, etc. The MA requires this brochure not only be given, but also explained and reviewed with the customer. Documentation in the customer's case record must support that this requirement was met. Provider agencies are directed to notify the Care Coordinator of changes in the customer's status. MCO policies and training outline the responsibilities of the Care Coordinator. These responsibilities include development and continual monitoring of the PCP

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

OA Process:

The HSP Rehabilitation Counselors conduct redeterminations of eligibility on an annual basis to review and/or revise the PCP with the customers or at times when there is a significant change. The PCP is designed to meet all needs of the customer as identified on the DON and to identify other needs or risks that the customer may have. If the customer's living situation has changed to the extent that services need to be revised, the HSP Rehabilitation Counselor may complete a temporary service plan addendum that modifies the level of care until the next reassessment is completed. If there are new needs or if the new cost of services exceeds the SCM, the HSP Counselor may complete a new reassessment.

As stated previously, the customer has the right to appeal if not satisfied with the amount, type, or change of services authorized. However, the HSP Rehabilitation Counselor is encouraged to have a conversation with the customer to attempt resolution of the issues. Customers have the right to appeal any decision made by the HSP Rehabilitation Counselor concerning their case. Customers are also informed of their responsibilities including completing and submitting necessary personal and contact information to facilitate timely eligibility determination and provision of services; how to properly complete, sign, and/or submit necessary documentation in accordance with program guidelines and assisting the OA with gathering the information necessary to determine eligibility; and reporting all changes in circumstances which may affect eligibility or continued eligibility for services to OA, as soon as known.

MCO Process:
For customers enrolled in an MCO, the Care Coordinator is the lead for waiver PCP development. MCO Care Coordinators are responsible to conduct reassessments on customers. At a minimum, the MCO will conduct a reassessment annually for customer. In addition, the MCO will conduct a face-to-face reassessment each time there is a significant change in the customer's condition, or the customer requests a reassessment. The MCO will analyze predictive-modeling reports and other surveillance data of all customers monthly to identify risk level changes. As risk levels change, reassessments will be completed as necessary and PCPs updated. The MCO will review PCPs of high risk (Level 3) customers at least every thirty (30) days, and of moderate risk (Level 2) customers at least every ninety (90) days and conduct reassessments as necessary based upon such reviews.

After each comprehensive assessment is completed in which the customers current status and needs are identified, a new PCP is completed. During the assessment, and as needed reassessments, the Care Coordinator educates the customer to call to request a change in the PCP if the customer's situation or needs change in-between assessments. The customer is educated to notify the Care Coordinator any time there is a change in their living or medical situation that may affect their need for services. The PCP can be adjusted in-between assessments to meet the customers immediate needs. Whenever there is a significant change condition, needs, or functioning (for example, hospitalization significantly impacting the customer's level of functioning), a new assessment is to be completed and additional services provided as needed.

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

The Care Coordinator is responsible for providing clear direction to the customer regarding their right to appeal whenever a reduction, termination, or suspension in service(s) occurs. The appeal rights are summarized in the PCP. The customer signs the PCP agreeing to the contents. If the customer requests an appeal, they must contact the MCO and request that services remain intact. If the customer appeals within a certain time frame, The services will then remain in place until the appeal process is exhausted, including the State fair hearing process. The customer must request that services be continued within 10 days of receiving the Adverse Determination Letter.

A contract amendment was finalized outlining requirements for informed consent, signing of the PCP by the customer and all providers responsible for implementing, and provision of a written copy of the PCP to all customers and providers responsible for the implementation of the PCP. Several rules under Illinois Department of Human Services' Home Services Program were updated to incorporate PCP provisions required by federal CMS pursuant to 42 CFR 441.301(c)(1)(2)(3). The rule changes were adopted effective January 24, 2019 in the following rules under Title 89: Rule 676, Program Description; Rule 677, Customer Rights and Responsibilities; Rule 684, Service Planning and Provision; and Rule 686, Provider Requirements, Type Services, and Rates of Payment.

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

OA Process:
The customer, and their identified representative(s) as needed or requested, are actively involved in the determination of eligibility and in the development of the person-centered service plan. The HSP Rehabilitation Counselor meets with the customer and their representative, at a time convenient to both, to complete the Determination of Need (DON) assessment. This structured interview process provides multiple opportunities for the customer and representative to participate and to express their impairments, needs and preferences for assistance in meeting the unmet needs. Customers are encouraged to be actively engaged in the process, to fully disclose all information, and to actively advocate for themselves. Once the level of impairment and need is identified through completion of the DON, the HSP counselor, the customer and as needed their representative, meet to develop a mutually agreed upon person-centered service plan. The counselor and customer determine the amount of time needed to complete the tasks where an unmet need was identified, and to identify the appropriate types of service providers to assist the customer in meeting the identified need. Once the person-centered service plan is complete, both the counselor and the customer or their representative sign the service plan showing all parties are in agreement with what was developed.

MCO Process:
The MCO Care Coordinators utilize a variety of comprehensive assessment tools to elicit a wide range of information from the customers and their representatives, as well as utilizing the OA-completed DON assessment, in developing a person-centered service plan with those customers enrolled in an MCO. Similarly, customers and their representatives, as needed, are actively engaged in the development of the person-centered service plan, with the number of approved service hours and the types of service providers mutually agreed upon by both parties in writing on the service plan document.

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

OA Process: The customer's HSP Rehabilitation Counselor obtains the customer's, or their representative's, signature on the mutually agreed upon person-centered service plan.

MCO Process: The MCO Care Coordinator obtains the customer's, or their representative's, signature on the mutually agreed upon person-centered service plan.

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 Process:
HSP Rehabilitation Counselors assess for customer needs, as well as evaluating risks. They work with the customer to identify the resources and strategies to mitigate these risks through the linkage and delivery of services, ultimately to prevent institutionalization and for the customer to be successful in community residency. These risks are identified in the assessment tools utilized and during the conversations and interviews that are critical elements of the process. For example, if the customer is at nutritional risk, utilizing a home care worker or home delivered meals service may be included in the PCP to mitigate this risk.

The HSP Rehabilitation Counselor and customer discuss a wide range of domains that may mitigate the risk. These domains include issues that impact the success of the waiver service or any other formal or informal supports employed to mitigate the risks. This systemic approach reviews many risk factors. These risk factors could encompass behavioral health concerns of the customer that may include depression, anxiety, abuse of alcohol or other substances including illegal substances and medications. Risk factors may also include the role of caregivers, physical health, and the occurrences and risks of falls.

Part of this risk mitigation discussion includes the consequences of negative choices. This discussion is maintained between the HSP Rehabilitation Counselor and the customer during initial assessment, and subsequent reassessments. The customer is assessed with respect to risks and potential risk factors, and the OA's ability to address any identified risks by the PCP. Severity of impairment is determined through the HSP Rehabilitation Counselor interview with the customer and is also supported by clinical information.

Provider agencies are required to have a policy for an all hazards disaster operations including, but not limited to, medical emergencies, home or site-related emergencies, customer-related emergencies, weather-related emergencies, and vehicle/transportation emergencies. For example, in-home service agencies train their homemakers to make additional meals for storage and reheating during times of inclement weather.

Every PCP must have a backup plan. The backup plan utilizes programs, services, and resources identified by the customer and HSP Rehabilitation Counselor. The backup plan is a companion document to the PCP. The backup plan articulates who has the responsibilities of mitigating or reducing risk. Just as a PCP indicates who has responsibility, so too does the companion backup plan.

If a risk or need is being mitigated by a provider agency, then the agency is responsible to assure that there is a backup plan in place. This is a requirement that is built into the agreement between OA and the provider. If the provider is an IP, the HSP Rehabilitation Counselor works with customer to develop a backup plan that could include using natural supports, non-paid caregivers, another IP, or an agency. Customers are encouraged to obtain two IPs that are familiar with their needs, so that there is always a trained backup caregiver available. Another option is to use a trained IP from a listing provided by a local Center for Independent Living (CIL).

Lastly, when a customer has lost an IP and is going through the interviewing and hiring process to obtain another personal assistant, the HSP Rehabilitation Counselor can authorize homemaker services to ensure services remain intact during the hiring process.

MCO Process:

For customers enrolled in an MCO, the Care Coordinator is the lead for PCP planning. The assessment for potential risk is included in the PCP process. The Care Coordinator is expected to incorporate and utilize the same strategies as describe above in the development of the PCP. In addition the MCOs use predictive modeling reports and other surveillance data, including claims data to identify risk level changes. Again, strategies to reduce, mitigate, and eliminate risks must be identified. In addition, the Care Coordinator develops the backup plan and works with the customer to ensure necessary arrangements are in place.

The Care Coordinator completes a comprehensive assessment and PCP process for every customer. This process includes identification of the customer's cognitive/emotional functioning, behavioral health, medication, living supports, environmental conditions, ADLs, IADLs, and health information. This process identifies risks that could encompass such domains as the behavioral health of the customer including depression, anxiety and the abuse of alcohol or other substances including illegal substances and medications; providing a crisis safety plan for a member with a behavioral

health condition; role of caregivers; physical health; occurrences and risks of falls. These are explored and addressed as they may increase and serve as barriers to the customers' ability to live as safely and independently as possible. All risks are identified and discussed in the PCP process. Interventions are developed to mitigate identified risk(s) and barriers and are mutually agreed upon by the customer and the Care Coordinator.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

OA Process:
Over 85% of the providers in the HSP program are IPs that are hired and trained by the consumer. HSP Rehabilitation Coordinator assist customers in identifying potential IPs as well as traditional providers. When an IP is chosen, the HSP Rehabilitation Counselor gives the customer a packet that includes information on self-direction including the IP Handbook, Customer's Rights and Responsibilities document, and IP Standards forms. HSP Rehabilitation Counselors receive intensive training on the array of services provided by the waiver. Additionally, counselors receive the rates and fee table that lists all service descriptions.

In some rural areas, despite the relatively high wages paid to IPs, the OA has difficulty maintaining providers due to transportation issues and, in times of good employment, due to the presence of other well-paying industry jobs. In these situations, HSP Rehabilitation Counselor provide ideas and other potential resources for customers to find available workers, and, of course in all instances the State works to ensure continued access to potential IPs and ensures that others services, such as agency services, are available when IPs are unavailable to assist a customer.

If an agency provider is chosen, the customer may choose to request a list of providers from the local Center for Independent Living. The customer may utilize the list as a resource, but he/she is not required to choose a provider from it. Each service provider is also encouraged to have its own brochures and advertising material available upon customer or counselor request. Customers and families are encouraged to visit providers before choosing that provider.

The OA provides a brochure that lists all services in the program for all new applicants. There is also a notation on the Home Services Application and Redetermination of Eligibility Agreement, IL-488-2450W that acknowledges that the customer received the list of services.

MCO Process:

For customers enrolled in an MCO, the Care Coordinator is the lead for waiver PCP development. The Care Coordinator will assist the customer in obtaining information about and selecting from among qualified providers of the waiver services in the PCP.

It is the Care Coordinator role to provide information about the available services and service providers and to answer any questions of the customer. The Care Coordinator assists the customer by supplying qualified and contracted provider information relevant to the services available in the service area that are selected by the customer. The Care Coordinator informs and supports the customer in selecting a provider to meet their needs particularly, if the customer does not have a preferred provider identified. The Care Coordinator maintains a current list of qualified and contracted service providers in the customer's geographic area which is made available to customers upon request. The customer is also educated of the availability of the MCO's provider list found on their website.

MCOs must have contracts with a sufficient number of such providers within each county in the contracting area to assure that the affiliated providers served at least 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 provider of such covered services, the MCO shall enter into contracts with at least two such providers, so long as such providers accept MCO rates, even if one served more than 80% of the customers, unless the MA grants MCO an exception. It is the MA goal that this will insure choice on behalf the member customer.

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 PCP, the PCP is subject to oversight from the MA. This oversight is accomplished through the MA's Quality Improvement System using a statistically valid sample representative sampling methodology having a 95% confidence level and a 5% margin of error. Once the sample is selected by the MA, it is provided to the reviewing entity responsible for monitoring the OA (a Quality Improvement Organization, or QIO) and MCOs (an External Quality Review Organization or EQRO). The MA supplies the QIO and EQRO with the specified monitoring review tool designed to ensure person-centered service planning processes were provided in accordance with § 441.301(c) and waiver requirements. The QIO and EQRO reviews customer records, case notes, person-centered services plans, claims data, etc in order to verify compliance with PMs.

The QIO determines a review schedule, based on the sample, and performs annual onsite record reviews to assess compliance with the performance measures (PM) as well as with all applicable state and federal requirements. Performance Review Reports of findings are shared with the OA and MA by individual PM, along with recommendations for remediation of findings and/or needed systemic improvement(s). Timeliness of remediation by the OA is reported back to the MA based on the requirements of each PM, either immediate, 30, 60, 90 days along with any remaining outstanding remediation that must be completed. The MA and QIO discuss review reports concerns and review schedules during bi-weekly meetings. Changes to the review or process occur whenever deemed necessary. Information related to the onsite record review is also shared and discussed during quarterly meetings between MA and OA. The MA and OA discuss PM results and determine if any system improvements are needed based on trends discovered during the review.

For the MCOs, the EQRO determines a review schedule, based on the sample, and performs quarterly onsite record reviews to assess compliance with the performance measures (PM) as well as with all applicable state and federal requirements. Performance Review Reports of findings are shared with the MA and MCO by individual PM, along with recommendations for remediation of findings and/or needed systemic improvement(s). Timeliness of remediation by the MCO is reported back to the MA based on the requirements of each PM, either immediate, 30, 60, 90 days along with any remaining outstanding remediation that needs completed. The MA and EQRO discuss review reports concerns and review schedules during regularly scheduled meetings. Changes to the review or process occur whenever deemed necessary Information related to the onsite record review is also shared and discussed during quarterly meetings between MA and MCO. The MA and MCO discuss PM results and determine if any system improvements are needed based on trends discovered during the review.

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.

MA Process
The State is committed to the adherence of the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5). The OA and the MCOs have responsibility for the completion and implementation of the PCP and responsibility to ensure customer health, safety and welfare. The PCP is monitored by the MA to ensure all customer risks, including health, safety and welfare, are addressed, and updated with a change in customer condition or need. MA oversight is completed through onsite monitoring using a statistically valid representative sampling methodology having a 95% confidence level and a +/- 5% margin of error. Once the sample is selected by the MA, it is provided to the reviewing entity responsible for monitoring the OA (a Quality Improvement Organization, or QIO) and MCOs (an External Quality Review Organization or EQRO). The QIO determines a review schedule, based on the sample, and performs annual comprehensive provider reviews and onsite record reviews at OA offices statewide to assess compliance with the performance measures (PM) as well as with all applicable state and federal requirements. For the MCOs, the EQRO determines a review schedule, based on the sample, and performs quarterly onsite record reviews to assess compliance with the performance measures (PM) as well as with all applicable state and federal requirements.

Monitoring activities for both the OA and MCOs include verifying services are furnished in accordance with the PCP and service authorizations, and customer needs are met. Case notes are reviewed to identify changes in condition and/or service needs and whether they resulted in PCP revisions if warranted. During the comprehensive provider reviews, customer interviews are conducted by the QIO to verify that services are delivered according to the PCP and the customer's needs are met.

Monitoring activities also include verifying effectiveness of the backup plan. The PCP is reviewed for evidence of a backup plan and that the plan meets the customer's needs. During the comprehensive provider reviews, customer interviews are conducted by the QIO to verify that the backup plan meets the customer's needs.

Customer health and welfare are also monitored. Review criteria ensures that processes are in place to identify, address, and report abuse, neglect, and misappropriation of funds. Incidents, complaints, and the reporting processes are also reviewed.

OA Process:
The HSP Rehabilitation Counselor is responsible for monitoring the implementation of the PCP, the availability and effectiveness of identified services and supports, and the customer's overall health and welfare.

To augment the MA quality reviews, the HSP Quality Assurance Unit staff conduct annual reviews to monitor implementation of the PCP and ensure updating occurs as needed. HSP Rehabilitation Counselor meet with customers, annually, at a minimum, and as needed based up on a change in condition or need. Implementation of the PCP is monitored, along with the availability and effectiveness of identified services and supports, and the customers overall health and welfare by the methods detailed below.

For customers using homemaker and agency providers, the HSP Rehabilitation Counselor reviews monthly progress reports, submitted by the agencies. These reports may trigger telephone contact with the customer or a face-to-face meeting. When issues are found, the counselor will follow-up with the customer and if necessary, adjust the PCP as needed.

For customers who have IPs, the counselor or other OA staff reviews billings twice a month to ensure services are provided in accordance with PCP. If there are issues with the provision of services, the HSP Rehabilitation Counselor will follow-up with the customer to rectify the situation.

The HSP Rehabilitation Counselor reviews all critical incident reports. When issues are found they are addressed on a case-by-case basis and the PCP may be amended as needed. All critical incidents are followed by the HSP Rehabilitation Counselor to resolution.

MCO Process:
The Care Coordinator is responsible for monitoring the implementation of the PCP, the availability and effectiveness of identified services and supports, and the customer's overall health, safety and welfare.

Each MCOs continuously monitors implementation of the PCP and ensure updating occurs as needed through internal quality assurance monitoring. The Care Coordinator meets with customers, quarterly, at a minimum, and as needed based

up on a change in condition or need.

Implementation of the PCP is monitored, along with the availability and effectiveness of identified services and supports, and the customers overall health and welfare by the methods detailed below.

For customers using homemaker, agency providers, or IPs; the Care Coordinator reviews claims submitted by the agencies against the PCP and service authorizations. This review may trigger telephone contact with the customer or a face-to-face meeting. When issues are found, the Care Coordinator will follow-up with the customer and if necessary, adjust the PCP as needed. If there are issues with the provision of services, the counselor will follow-up with the customer to rectify the situation.

The Care Coordinator reviews all critical incident reports. When issues are found they are addressed on a case-by-case basis and the PCP may be amended as needed. All critical incidents are followed by the Care Coordinator to resolution.

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 customers' PCPs that address all personal goals identified by the assessment. D: Total number of OA and MCO customers' PCPs reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D4: Number and percent of OA and MCO customers who have Individual Provider (IP) services whose Person-Centered Plans (PCP) included a back up plan. N: Number of OA and MCO customers who have IP services whose PCP included a back up plan. D: Total number of OA and MCO customers who have IP services that were reviewed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D5: Number and percent of OA customers who received annual contact by their HSP Rehabilitation Counselor in an effort to monitor service provision or gaps in service delivery. N: Number of OA customers who received annual contact by their HSP Rehabilitation Counselor in an effort to monitor service provision or gaps in service delivery. D: Total number of OA customers reviewed.

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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 who received contact every 90 days by their MCO Care Coordinator in an effort to monitor service provision or gaps in service delivery. N: Number of MCO customers who received contact every 90 days by their MCO Care Coordinator in an effort to monitor service provision or gaps in service delivery. D: Total number of MCO customers reviewed.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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 Person Centered Plan (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):
Record reviews, on-site
If 'Other' is selected, specify:

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

Agency		
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level with 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:
D8: Number and percent of OA and MCO waiver customers that received updates to the Person Centered Plan (PCP) when there was a change in customer need. N: Number of OA and MCO waiver customers that received updates to the PCP when there was a change in customer need. D: Total number of OA and MCO waiver customers where a change in need was identified that were reviewed.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D9: Number and percent of OA and MCO customers who received services in the type, scope, amount, duration, and frequency as specified in the Person Centered

Plan (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):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

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

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level with 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.

The Medicaid agency, HFS, will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs. For those functions delegated to the OA and the MCOs, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the OA and MCOs.

On a random and annual basis, DRS sends a survey to program customers to determine customer satisfaction concerning the provision of waiver services. Information gathered from surveys are evaluated and considered by administration with respect to potential need for program modifications and improvements.

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

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with Integrated Care Program MCOs providing waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the EQRO, which uses consumer surveys and quarterly reports, the MA monitors both compliance of PMs and timeliness of remediation for those waiver customers enrolled in a MCO. 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.

D1: If the PCP does not address required items, the OA/MA will require the PCP be corrected and will provide training of the HSP Rehabilitation Counselor or MCO Care Coordinator. Remediation must be completed within 60 days.

D2: If the PCP does not address required items, the OA/MA will require the PCP be corrected and will provide training of the HSP Rehabilitation Counselor or MCO Care Coordinator. Remediation must be completed within 60 days.

D3: If the PCP does not address required items, the OA/MA will require the PCP be corrected and will provide training of the HSP Rehabilitation Counselor or MCO Care Coordinator. Remediation must be completed within 60 days.

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

D5: MA/OA will require customer be contacted and provide training to the HSP Rehabilitation Counselor. Remediation must be completed within 60 days.

D6: MA/OA 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. If PCPs are not updated when there is documentation that a customer's needs changed, the OA/MCO will require an update. In both cases the OA/MCO may require a plan of correction for Care Coordinator training. Remediation within 60 days.

D8: If plans do not address required items, the OA/MA will require that the plans be corrected and provide training of case managers. Remediation must be completed within 60 days.

D9: If a customer does not receive services as specified in the PCP, the OA/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 OA/MCO may also provide training to the HSP OA/MCO Care Coordinator. If the issue appears to be fraudulent, it will be reported by the OA/MA. Remediation must be completed within 60 days.

D10: The OA/MCO will assure that choice was provided as shown by the correction of documentation to indicate customer choice. The OA/MCO may also provide training to 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:	☑ **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)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Illinois has offered customer direction in the home services program since the early 1980s. Customers may either hire their own Individual Provider (IP) or use an agency provider. Customers typically opt to use IPs.

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

As the employer, customers must sign timesheets and affirming the accuracy of the time worked in the Electronic Visit Verification (EVV) system to verify the hours that the IP has worked. Signed timesheets are then forwarded to the Operating Agency (OA) local office for review and comparison with the clock-in/out times from EVV and payment is issued. The OA has developed a payroll system to pay IPs twice monthly. The payroll system withholds unemployment, FICA, other employee benefits, and other required or requested deductions.

Currently, the OA requires both paper timesheets and Electronic Visit Verification (EVV). The OA is working toward eliminating timesheets and using EVV only.

IP services are provided in accordance with the PCP. In the event that it is determined that a customer is unable to appropriately supervise an IP, the service may be changed to homemaker or another service. When this occurs, the customer is advised that IP services will continue if he/she disagrees with this decision until the appeal process has been exhausted. Conversely, IP services would not continue in the instances of abuse, neglect, financial exploitation, fraudulent activity, or if IP services have not yet begun. Homemaker agencies provide a level of service similar to that of an IP.

Homemaker agencies are utilized when customers do not have the capacity to appropriately supervise an IP, or when an IP cannot be located for the customer. Homemakers are supervised by their respective homemaker agency. Again, the customer may select an agency of their choice. Homemaker services are provided in accordance with the PCP, and as specified on the OA vendor authorization. Other individual (non-agency) providers may include home health aides, licensed practical nurses, registered nurses, or therapists. Customers may still opt to select their preferred provider for nursing care or therapy, however due to the clinical nature of nursing and therapy services, customers do not supervise services provided by these IPs. Services are provided in accordance with appropriately designed and approved clinical plans.

Clinical services are only provided as prescribed by the physician. Although the customer exercises self-direction as indicated above, the actual provision of clinical services must be provided in accordance with clinical standards and must be prescribed. For other agency-provided services, customers still have the option of determining which service provider is authorized to provide services but may not have direct supervisory responsibility over non-IP level of care. For example, customers have the right to select specific agencies to provide services according to level of care identified on the PCP. Services provided by agencies are provided in accordance to the customer's PCP, and with respect to contractual or agency standards, depending upon the level of care. Services provided by agency personnel are supervised by management staff from respective agencies.

Payment for agency providers is authorized at the local OA office.

For customers enrolled in an MCO, the MCO Care Coordinator is the lead for waiver service planning. Customer direction is the cornerstone of the managed care demonstration project. MCOs allow customers, who elect to and can safely direct their own services, the opportunity and supports needed. Opportunities for customer direction, at minimum remain the same as described above. This includes that customers will actively participate in their own PCP development, including the selection of providers and services to receive or not receive, and maintain employer authority.

There are no differences between the MCO and fee for service customers in the delivery of customer directed services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (•) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [✓] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- (•) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ( ) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

During the initial assessment, subsequent redeterminations, and the Person Centered Plan (PCP) development process, the Home Services Program (HSP) Rehabilitation Counselors provide information to the customers about customer directed services and choice of worker. Customers are given a "Customer Hiring a Provider - Document Packet", which includes information about managing an Individual Provider (IP), information about how to file an appeal, an HSP Fraud Brochure, and information required to enroll an IP.

The IP packet includes the following: Medicaid Waiver Provider Agreement form, Individual Provider Standards, Individual Provider Payment Policies, IMPACT enrollment information, as well as other forms required to enroll the IP.

The customer also receives the HSP Application and Redetermination of Eligibility Agreement that contains information such as: customer rights and responsibilities; abuse and neglect reporting; choice, and services. HSP Rehabilitation Counselors review this form with customers when there is a change in service or minimally, at each redetermination. Customers initial each section and sign the agreement indicating that the HSP Rehabilitation Counselor has reviewed it with them and that they understand the information.

If a customer elects to change from an agency to an IP, the HSP Rehabilitation Counselor sends a Vendor Authorization for Services form to the agency to terminate services. This form outlines the services and the termination date. The customer then selects the IP and the documents in the IP packet are completed.

For customers enrolled in a Managed Care Organizations (MCOs), the MCO Care Coordinator is the lead for waiver PCP development. The MCO Care Coordinator is responsible for furnishing the information as part of the PCP process to inform decision-making concerning customer direction. The content of the information at minimum remains the same as described above.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

● **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A customer is considered anyone who: 1) has been referred to the Home Services Program (HSP) for a determination of eligibility for services; 2) has applied for services through HSP; 3) is receiving services through HSP or MCO; or 4) has received services through HSP or MCO.

If the customer is unable to satisfy any of his/her obligations under the HSP or MCO, including, without limitation, the obligation to serve as the employer of the Individual Provider (IP), the customer's parent, family member, guardian, or duly authorized representative may act on behalf of the customer and is included within the definition of " customer", as used throughout this Part.

A legally responsible family member is a spouse, parent of a child who is under age 18 or a legal guardian of a customer who is under age 18. Waiver services may be directed by a legally responsible family member of a customer.

Non-legal representatives will only participate in the assessment process when so designated by the customer and will only participate in the decision-making process when approved by the customer. The customer is encouraged to have significant others and members of his/her circle of support present during assessments.

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

HSP Rehabilitation Counselors meet with customers at least annually. MCO Care Coordinators complete an in person visit every 90 days in the customer's home. Customers are provided with an information folder which includes information about their case, their appeal rights, and contact information for their counselor or care coordinator. Additional brochures have been described previously. Customers are advised to contact the OA local office or MCO if their situation changes, any time there is a problem, or if there is a change in need for service.

HSP Rehabilitation Counselors and MCO Care Coordinators are mandated reporters of abuse, neglect, and financial exploitation. When there are allegations or suspicions of abuse and/or neglect, Adult Protective Services is notified. If HSP Rehabilitation Counselors and MCO Care Coordinators believes that the customer is in immediate danger the local police are notified. In cases of suspected abuse by a service provider, that provider is removed from service, and a new provider is assigned to the customer.

Customers are invited to participate in all aspects of their assessment and Person Centered Plan (PCP) development process to the best of their ability to understand and contribute to the process. Legally responsible parties or legal representatives may be part of the assessment and PCP development process. Customers who do not have a legal representative are offered to invite a representative to each assessment and redetermination visit to support or assist them during the assessment and PCP development process. The customer may also wish to have a non-legal representatives assist them in decision making or navigating the waiver and health plan services.

If the customer can direct their care, then non-legal representatives will participate in the assessment, PCP, and decision-making process only when approved by the customer.

Customers who are not able to direct their own care may have non-legal representatives support and assist in the assessment and PCP development process if they are acting in the best interest of the customer. Safeguards are in place to ensure non-legal representatives act in the best interest of the customer including quarterly assessments by the Care Coordinator to confirm customer's needs are being met according to the PCP, informal supports are being provided as previously identified in the assessment, and other contacts done by the HSP Rehabilitation Counselor to ensure service implementation and well-being for a customer.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Respite	☑	☐
Physical Therapy	☑	☐
Home Health Aide	☑	☐
Individual Provider	☑	☐
In-Home Shift Nursing	☑	☐
Occupational Therapy	☑	☐
Speech Therapy	☑	☐
Intermittent Nursing	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☑ **Governmental entities**

☐ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Fiscal Management Services (FMS) are provided by the Operating Agency (OA) in accordance with standard accounting and auditing procedures. The OA administers FMS that are aligned with fiscal management procedures that are utilized by the Medicaid Agency (MA) Medicaid program. This includes quality assurance procedures to verify services are provided and paid in accordance with policy, rules, and regulations.

Illinois does not procure an FMS as it is performed by a state agency. The OA operates a payroll system for Individual Providers (IP) that are customer directed. The Internal Revenue Service recognizes the customer and the OA as the co-employer of record. The customer must sign service calendars to verify the hours worked. The IP sends the hours worked to the OA local office for review and approval. The local OA office then enters the payment into the WebCM System that includes internal edits to assure that the correct rates are applied and that the claims are within the allowable service cost maximum. The OA state-operated payroll system pays IPs twice monthly. The payroll system withholds unemployment, FICA, union dues and other deductions as requested by the providers. All worker's compensation claims come through the OA and are processed by the Illinois Department of Central Management Services, Risk Management. The OA's case management system provides guidance and oversight of customer's hiring IPs. The Home Care Ombudsman Program through the Illinois Department on Aging is available to provide advocacy and guidance to customers.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

No external agencies are utilizied for FMS. This is a function of the operating agency.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

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

  Specify:

Supports furnished when the participant exercises budget authority:

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

  Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the**

Medicaid agency

☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

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

The FMS is part of the State of Illinois. Monitoring occurs as a routine function of the fiscal oversight processes in both the Operating Agency (OA) and the Medicaid Agency (MA).

HealthCare and Family Service (HFS), as the Medicaid single State agency, receives and reviews the OA's quarterly administrative claim that includes administrative expenditures of the OA. Each quarter, the entire claim is reviewed for variances from prior quarters. For instance of variances, the MA requests and reviews a detailed expenditure documentation to assure that the costs are adequately supported. Any discrepancies are corrected in the next quarterly claim.

In addition, as referenced in Section I-1 (b) of the waiver applicants, the MA conducts post claim reviews of waiver claims and reviews rates from the perspective of correct rate applied for a specific waiver service.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Customers are informed of the type of availability of services offered through the Persons with Disabilities waiver. Additionally, customers have the right to choose their service providers and which Home Services Program (HSP) approved vendor will provide them with goods or services (Section 677.40 Freedom of Choice). At initial eligibility determination, customers are informed of the variety of services available through the "Customer Guidance on Rights/Responsibilities/Appeal Procedures (HSP-1)" and are offered this information at subsequent redeterminations as well. This document provides detailed information on waiver services and is explained to the customer during determinations.

HSP Rehabilitation Counselors are responsible for providing information and support to customers. Customer rights and responsibilities are explained to the customers, as well as the purpose and scope of the program, and information concerning the types of available services.
Customers using Individual Provider (IP) services are required to collect and certify certain information for each IP used. If the customer does not complete and submit the IP Standards form (IL 488-2112, revised 12/13) before the IP begins employment, it may result in non-payment to the IP and ineligibility for further services for the customer.

For customers enrolled in a Managed Care Organization (MCO), the MCO Care Coordinator is the lead for waiver Person Centered Plan (PCP) development. The MCO Care Coordinator is responsible for providing the information and assistance in support of customer direction.

Customers are informed about their right of self-direction during the initial eligibility determination and subsequent redeterminations. This is reviewed with the customer through a variety of methods:
• customer choice and right of self-direction is reviewed on the "Application and Redetermination of Eligibility Agreement."
• Recommendations, evidence of training, and physician approval to complete incidental health care tasks are identified on the "Individual Provider Standards" form.
• Review of the IP's performance and customer satisfaction are reviewed on the "Individual Provider Evaluation" form.

All information is discussed with the customer, and the customer signs the forms to indicate that the information has been reviewed. Additionally, customers are offered the opportunity to complete background checks on IPs. MCO customers are also provided the "Points to Ponder" document to assist in making decisions on self-directed services. All customers (MCO and Fee for Service (FFS)), are required to complete IP evaluations. The MCO and the Operating Agency are responsible for assuring the evaluations are completed and for handling any issues of concern.

The Home Care Ombudsman Program is available to all customers (both MCO and FFS). This program is administered through the Illinois Department on Aging's Long Term Care Ombudsman Program.

☑ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	☐
Adult Day Service	☐
Physical Therapy	☐
Home Health Aide	☐
Individual Provider	☐
Home Delivered Meals	☐
Specialized Medical Equipment	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
In-Home Shift Nursing	☐
Occupational Therapy	☐
Personal Emergency Response System	☐
Speech Therapy	☐
Homemaker	☐
Environmental Accessibility Adaptations	☐
Intermittent Nursing	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

There are two primary entities that furnish supports to customers regarding customer direction, the Home Services Program (HSP) Rehabilitation Counselors and the Centers for Independent Living (CIL). HSP administration also provides ongoing support and consultation to the HSP Rehabilitation Counselors in order to facilitate their support of customer direction.

The CILs are located throughout the state and provide training for customers on how to manage their Individual Providers (IPs).

At each redetermination, the HSP Rehabilitation Counselor discusses the rights and responsibilities related to having an IP. Each customer receives a brochure titled "HSP Customer Guidance for Managing Providers", that discusses the issues of hiring family members as caregivers.

The Operating Agency (OA) Quality Assurance unit and the Medicaid Agency (MA) conduct annual reviews of consumer records. The OA and the MA meet quarterly to discuss monitoring findings and overall quality management issues. Issues identified through monitoring are discussed and addressed both individually and systemically.

For customers enrolled in a Managed Care Organization (MCO), the MCO Care Coordinator is the lead for waiver Person Centered Plan development. The MCO Care Coordinator is responsible for providing the information and assistance in support of customer direction. The MA monitors the performance through analysis of reports, onsite monitoring, desk audits and interviews for those waiver customers enrolled in an MCO. Customers in MCOs are included in the representative sampling.

There are no differences between the MCO and Fee for Service in the monitoring of customers who self-direct services. These customers have an equal opportunity of being selected in the representative sample.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

The Illinois Department on Aging offers an independent entity called the Home Care Ombudsman Program (HCOP) which helps customers with disabilities receive quality services by advocating for their interests and helping them identify resources, understand procedures, resolve problems, and protect their rights in the rehabilitation process, employment, and home services.

HCOP services include:

-Assisting customers with problems they experience in seeking or receiving services.

-Trying to resolve issues at the lowest possible level (such as the local office), using advocacy skills, dispute resolution, and negotiation.

-Assisting or representing customers in their appeals of decisions regarding services and, if necessary, represent them in court.

-Working with the department, community groups, and advocacy organizations to resolve system problems.

-Providing public education programs on the rights of customers with disabilities and other related issues.

-Providing information and referral to related services.
When a complaint is presented to the Ombudsman, the Ombudsman representative brings the customer's complaints to one of the Operating Agency's (OA) zone offices. An Ombudsman representative is assigned to each zone and is responsible for handling complaints and questions in his/her zone. The Ombudsman representatives meet weekly to ensure consistent responses.

The OA provides each customer with a copy of the Home Services Program (HSP) Appeal Fact Sheet initially, at each redetermination and upon request. The HSP includes information on the right to appeal. Ombudsman representatives are also available to assist customers through the appeal process.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

During the Person Centered Plan (PCP) development process, Home Services Program (HSP) Rehabilitation Counselor review many factors to determine if the customer has the ability to self-direct. Examples of items reviewed would include medical information, psychological information, and interviews with the customer and their family members.

If the customer has the capacity to self-direct and chooses an Individual Provider (IP), the PCP is developed, and the customer is provided information about becoming an employer of the IP.

If the customer does not have the capacity to self-direct, he or she may choose a family member or guardian to manage the IP or they may choose an agency-based provider to provide their service.

If a customer chooses to self-direct and there are problems with the IP such as fraud or abuse by the customer; or situations where the customer's physical or mental health regresses, the HSP Rehabilitation Counselor will work with the customer to find an agency provider to replace the IP. Like any change in the PCP, this action may be appealed. Until the appeal is resolved, services will remain at the same level if the customer asks for continuation of services within 10 days of receiving the adverse determination letter. When transitioning from self-directed to agency-based services, the HSP Rehabilitation Counselor assures that there are no disruptions in services.

The Centers for Independent Living (CIL), in conjunction with the Operating Agency (OA) provides training to assist customers in the management of Individual Providers (IP). When a customer goes from self-directing services to receiving agency-based services and wants to go back to self-direction, the OA suggests that the customer participate in the training.

When a customer is in between IPs, the OA immediately increases the PCP and contacts a homemaker agency to maintain continuity of care until the customer finds a new IP.

For customers enrolled in a Managed Care Organization (MCO), the MCO Care Coordinator is the lead for waiver PCP development, implementation, and monitoring. The MCO Care Coordinator is responsible for providing needed supports for customer direction. The MCO Care Coordinator will assist the customer to choose alternate services and ensure supports are in place for continuity of care, health and welfare during the transition to an agency-based services.

All enrolled waiver customers will be offered the opportunity to direct all, none, or a portion of their services. A waiver customer who selects to direct none or a portion of their services can obtain their waiver services through agency-based service providers.

All waiver customers who select to direct their services using an IP can at any time terminate that choice and transition to an agency-based service provider. In order to assure the customer's health and safety, and to ensure that no interruption of services occur, the MCO will coordinate the transition from self-direction IP services to agency-based service providers.

Voluntary terminations will be recorded on the customer's PCP and will be indicated by the customer's approval of the PCP. Services provided by an IP will only be provided when it has been determined by the HSP Rehabilitation Counselor that the customer can effectively supervise the IP. In cases where the HSP Rehabilitation Counselor determines that the IP cannot meet the needs in the PCP, the customer cannot manage an IP, or the customer's health or safety is at risk, the HSP Rehabilitation Counselor will acquire homemaker services through an agency-based provider. These services will be provided in accordance with the PCP.

For customers enrolled in an MCO, the MCO Care Coordinator will provide the necessary supports to assure continuity of services and customer's health and welfare during the transition.

Services provided by a IP will only be provided when it has been determined by the MCO's Care Coordinator that the customer has the ability to supervise the IP.

In cases where the MCO's Care Coordinator determines that the IP cannot meet the needs of the member outlined in the PCP, or the customer cannot manage a IP (and if the customer has no reliable person available to assist in managing the IP), or the customer's health or safety is at risk by continuing to use a IP, the MCO Care Coordinator will consider the need to terminate the customer directed service involuntarily.

Prior to terminating any customer directed service the MCO Care Coordinator will send the customer a Notice of Action that provides the customer with information as to why their service is being terminated or reduced and includes their rights to an appeal and a fair hearing process.

The MCO Care Coordinator will replace the customer directed service with comparable agency-based services and do so timely to prevent a gap in service or care. Customers maintain the right to choose an agency-based provider in the MCO's contracted provider network. The PCP will be updated to reflect any changes.

The OA and MCOs use a standard process for determining the customer's ability to self-direct. If the customer is unable to communicate or has cognitive or emotional limitations that negatively impact their communication or decision-making ability, the HSP Rehabilitation Counselor or the MCO Care Coordinator may determine that the customer does not have the capacity to self-direct their services. This determination is typically supported from case documentation, which can be obtained from a number of sources, including but not limited to medical reports, psychological and neuropsychological evaluations, the HSP Rehabilitation Counselor or the MCO Care Coordinator observations, documented instances showing the inability to properly manage an IP, information from the customer's family and/or representative, and failure to pass the Mini-Mental Status Examination on the Determination of Need. If it is determined that a customer cannot self-direct, the HSP Rehabilitation Counselor or the MCO Care Coordinator will identify a legal guardian, power of attorney, or other individual to represent the customer and to assist with the determination and PCP development process.

The MCOs have received initial and ongoing training from the OA regarding customer direction and oversight of IPs. The OA has shared their provider standards with the MCOs that include information on how to determine if the IP can meet the customer's needs. The OA also provides guidance on how to determine when an IP is not meeting needs of the customer and when it is appropriate to change from an IP to an agency-based provider. The Medicaid Agency and OA do not specifically monitor the decisions that are made by the MCO.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Services provided by an Individual Provider (IP) will only be provided when it has been determined by the Home Services Program (HSP) Rehabilitation Counselor that the customer has the ability to supervise the IP. In cases where the HSP Rehabilitation Counselor determines that the IP cannot meet the needs in the Person Centered Plan (PCP), the customer cannot manage an IP, or the customer's health or safety is at risk; the HSP Rehabilitation Counselor will acquire services through an agency-based provider. These services will be provided in accordance with the PCP.

For customers enrolled in an MCO, the MCO Care Coordinator will provide the necessary supports to assure continuity of services and the customer's health and welfare during the transition.

Services provided by an IP will only be provided when it has been determined by the MCO's Care Coordinator that the customer has the ability to supervise the IP.

In cases where the MCO's Care Coordinator determines that the IP cannot meet the needs of the customer outlined in the PCP, or the customer cannot manage an IP (and if the customer has no reliable person available to assist in managing the IP), or the customer's health or safety is at risk by continuing to use an IP, the MCO Care Coordinator will consider the need to terminate the customer directed service involuntarily.

Prior to terminating any customer directed service the MCO Care Coordinator will send the customer a Notice of Action that provides the customer with information as to why their service is being terminated or reduced and includes their rights to an appeal and a fair hearing process.

The MCO Care Coordinator will replace the customer directed service with comparable agency-based services and do so timely to prevent a gap in service or care. Customers maintain the right to choose an agency provider in the MCO's contracted provider network. The customer PCP will be updated to reflect any changes.

The Operating Agency (OA) and MCOs use a standard process for determining the customer's ability to self-direct. If the customer is unable to communicate or has cognitive or emotional limitations that negatively impact their communication or decision-making ability, the HSP Rehabilitation Counselor or the MCO Care Coordinator may determine that the customer does not have the capacity to self-direct their services. This determination is typically supported from case documentation, which can be obtained from a number of sources, including but not limited to: medical reports, psychological and neuropsychological evaluations, HSP Rehabilitation Counselor or the MCO Care Coordinator's observations, documented instances showing the inability to properly manage an IP, information from the customer's family and/or representative, and failure to pass the Mini-Mental Status Examination on the Determination of Need. If it is determined that a customer cannot self-direct, the HSP Rehabilitation Counselor or the MCO Care Coordinator will identify a legal guardian, power of attorney, or other individual to represent the customer and to assist with the determination and PCP development process.

The MCOs have received initial and ongoing training from the OA regarding customer direction and oversight of IPs. The OA has shared their provider standards with the MCOs that include information on how to determine if the IP can meet the customer's needs. The OA also provides guidance on how to determine when an IP is not meeting a customer's needs and when it is appropriate to change from an IP to an agency-based provider. The Medicaid Agency and OA do not specifically monitor the decisions that are made by the MCO.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	33053	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 2	35091	
Year 3	37256	
Year 4	39554	
Year 5	41993	

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The co-employer is the State of Illinois, Division of Rehabilitation Services.

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☑ **Hire staff common law employer**

☑ **Verify staff qualifications**

☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

If a customer requests that a criminal background check must be completed, the Operating Agency obtains the criminal background check on behalf of the customer and pays all costs associated with acquiring the background check.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☑ **Schedule staff**

☑ **Orient and instruct staff in duties**

☑ **Supervise staff**

☑ **Evaluate staff performance**

☑ **Verify time worked by staff and approve time sheets**

☑ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Eligible customers (or their parent or legal guardian) will be informed of the feasible alternatives available under the waiver at the time they make application for waiver services. The Choice Form is explained to the customer and alternative providers in the area presented in order for the customer to make an informed choice between waiver and institutional services. Customers may consider other potential providers with visits arranged by the HSP Rehabilitation Counselor before they choose services.

For the fee-for-service customers, the fair hearing process is explained to the customer or legal guardian at the time of initial application, upon redetermination for the program, and upon any change in services with which the customer does not agree. Rules for fair hearings are found at 89 Il. Adm. Code, Part 510, Appeals and Hearings, and are summarized throughout this section. Customers enrolled in a Managed Care Organization (MCO) must first file for an internal appeal with the MCO. If the appeal is upheld, customers have the right to request a fair hearing with final decision being made by the Secretary of the Department of Human Services, pursuant to an intergovernmental agreement between the Medicaid Agency and the Operating Agency. The fair hearings process is the same for all customers, including those enrolled with MCOs.

Example of when a customer may request a fair hearing:
- Following refusal by the OA to provide any service it is authorized to provide,
- Modification of any service currently provided to the customer by the OA, termination of a service or case closure, unless agreed to by the customer and the OA,
- Determination that a customer is ineligible for services.

Notice is provided to the customer by the HSP Rehabilitation Counselor for each of the following adverse actions. Waiver services shall be denied or terminated, and case closure can be initiated at any time the customer:
-Refuses services or further services;
-Moves from the State of Illinois or cannot be located or contacted;
-Dies;
-Is institutionalized and not expected to be released for a period to exceed 60 calendar days;
-Is determined to have a projected service cost above that of the projected cost of institutionalization, with the exceptions found at 89 Il. Adm. Code 682.500(a), 682.520, and 684.70(c);
-Has been referred to another agency for the same or similar services and no longer requires or is eligible for HSP services;
-Fails to conduct himself/herself in an appropriate manner (e.g., physical, sexual or repeated verbal abuse by a customer against a DHS employee, provider or agent providing services through the OA; knowingly provides false information; or performs illegal activity that would directly and adversely affect the HSP);
-Is not, or is no longer, at risk of institutionalization due to improvement of his/her condition;
-Fails to meet other eligibility criteria as found at 89 Il. Adm. Code 682 as a result of an initial determination of eligibility or redetermination of eligibility;
-Fails to cooperate (e.g., refuses to complete and sign necessary forms, fails to keep appointments, fails to maintain adequate providers) or
-Cannot have a safe and adequate person centered plan developed for him/her as a result of the original determination of eligibility or redetermination of eligibility.

When an HSP Rehabilitation counselor makes an adverse case decision, the customer will receive a service notice that explains the decision and informs the customer of his/her right to appeal. The service notice is sent to the customer at least 15 days prior to the effective date of the action. The HSP Rehabilitation Counselor is responsible to notify the customer immediately after the decision. If the customer desires assistance during the hearing, he/she may request such assistance from the Home Care Ombudsman Program. Personnel within the Ombudsman program are impartial advocates who assist the customer during the appeal process. The service notice indicates that services will continue until after the hearing officer renders a decision. A copy of the service notice is retained in the case file. When available, a copy of the request for appeal may also be in the service file and will always be maintained in the appeal file under the DHS Division of Hearings and Appeals.

As stated above, customers enrolled in an MCO must first file for an internal appeal with the MCO. If the appeal is upheld, the customer has the right to request a fair hearing with final decision being made by the Secretary of the Department of Human Services. The Medicaid Agency's (MA) fair hearings process is the same for all customers, including those enrolled with MCOs. MCOs are required to have a formally structured appeal system that complies with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. 438 to handle all appeals subject to the provisions of such sections of the Act and C.F.R. (including, without limitation, procedures to ensure expedited decision making when an customer's health so necessitates and procedures allowing for an external independent review of appeals that are denied by the MCO). The MA reviews and approves the MCO's appeal process guidelines, in compliance with the MCO Contract, Sections 5.30.2.1 and 5.21.1.10.

MCOs inform customers about the fair hearing process in the customer handbook distributed at the time of enrollment (MCO Contract Section 5.21.8.4). Information about the fair hearing process is also published on the MCOs' websites contained within

the MCO Customer Handbook. 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 a 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 MCO. Per 42 CFR 438.406 (a), MCOs are required to help customers in filing an internal appeal or in accessing the fair hearing process including assistance in completing forms and completing other procedural steps. This includes providing interpreter services, translation assistance, assistance to the hearing impaired (including toll-free numbers that have adequate TTY/TTD) and assisting those with limited English proficiency. The MCO must make oral interpretation services available free of charge in all languages to all customers who need assistance. This is also required by the MCO Contract Section 5.21.4.3.

At the time of the initial decision by the MCO to deny a requested non-participating provider, 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 and authorized representative, if applicable. In addition, the MCOs provides a Notice of Appeal Resolution, to the customer at the time of the internal grievance or appeal resolution. If the resolution is not wholly in favor of the customer, the customer may elect to request a fair hearing from the Medicaid Agency. The Notice of Appeal Resolution includes the description of the process for requesting a Fair Hearing.

Each MCO submits a quarterly Grievance and Appeals summary report to the MA. The format of each report is dictated by the MA (MCO Contract Section 5.30.3.11). The quarterly summary report of Grievances and Appeals filed by customers is organized by categories of medical necessity reviews, access to care, quality of care, transportation, pharmacy, LTSS services and other issues. It includes the total grievance and appeals per 1,000 customers. Additionally, it includes a summary count of any such appeals received during the reporting period, including those that go through fair hearings.

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

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

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

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

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

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

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.

Prior to scheduling a hearing, the customer may be offered the opportunity to participate in an informal resolution conference. The primary goal of this exercise is to attempt to reach mutual resolution of the issues being appealed. Customers may request an Informal Resolution Conference anytime between the filing of the appeal and the issuance of the Final Administrative Decision - this may even occur after the hearing. The informal resolution conference may be requested by contacting the office of which the customer receives services. (Customers Guidance on Rights/Responsibilities/Appeals Procedures; Section 510.100 Informal Resolution Conference.)

Informal resolution offers an opportunity to resolve differences prior to issuance of a final administrative decision. This may take the place of the hearing, if all parties agree on the resolution, but is not required. This is offered as another mechanism through which to address customer's concerns. Informal resolution is conducted by the OA central office staff, and includes the OA Counselor and customer, and other individuals as required, although this is ordinarily kept as informal as possible. If the issues under appeal are resolved according to the satisfaction of all parties, the customer's services will reflect this, the customer will withdraw the appeal, and the OA Division of Administrative Hearings will close the appeal file.

The OA's Division of Administrative Hearings utilizes impartial hearing officers and works with the Home Services Program of the OA to schedule hearings. The hearings are scheduled according to availability of all parties. At least three days prior to the hearing, information submitted by each customer is forwarded to all parties. The hearing officer conducts the hearing. The hearing office will render a decision within 90 days following the hearing. The final administrative decision is made by the DHS Secretary of Human Services. As the single state Medicaid Agency, HFS monitors the Medicaid customer appeal hearing system, including the quality and accuracy of the final decisions made by DHS. DHS Bureau of Hearings and HFS Bureau of Administrative Hearings work in partnership in the implementation of the Intergovernmental Agreement (IGA) goals. The IGA was signed in 2014 and is reviewed annually. Since then, DHS and HFS have a new shared case management system (IES appeals module), which facilitates all the access to number, status, and disposition of Medicaid appeals. DHS and HFS staff members continuously engage in collaborative efforts to maintain the efficiency and to improve the IES appeal module, which contains the data of Medicaid appeals.

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 Illinois Department of Human Services Division of Rehabilitation Services operates the grievance and complaint system.

For participants enrolled in an 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 OA and/or a provider to make an authorization decision. This includes a grievance related to the OA's or a provider's performance of person-centered planning process, person-centered service plan, review of person-centered service plan, home and community-based settings, settings that are not home and community-based, home and community-based settings compliance and transition

For the MCO populations, 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.

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

Customers are informed about their right to file a grievance and directions on the grievance process at enrollment, at each assessment and reassessment, and with information documented on the OA's website at https://www.dhs.state.il.us/. Providers and subcontractors are provided with a standardized notice outlining the grievance process and expectations for providers. This notice will be shared with providers 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 no Authorized Representative Form is on file, a customer may complete an Approved Representative Form to document the request. The OA can provide assistance to a customer in filing a grievance if requested. Customers may request assistance from the Division of Rehabilitation Services via the Customer Complaint toll-free hotline number, via the dedicated DHS.DRSCustomerComplaint@illinois.gov email account, or in writing to DRS. For customers who need language services (written or oral interpretation) the OA will utilize both internally available bilingual agency staff, as well as the state-contracted Propio Language Service.

For fee-for-service customers, the OA will acknowledge each grievance received with a written letter of acknowledgement. The OA will resolve grievances as quickly as possible but within 90 days of the receipt of the grievance. The grievance process may be extended by up to 14 days if requested by the customer or if the OA determines and documents a need for additional information that is in the best interest of the customer. If the timeline is extended, the customer will be notified promptly and will get written notification within 2 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 his or her grievance orally or in writing, using any method of communication he or she prefers. 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.

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

The OA's grievance process is documented in the DRS Customer Complaint policy on the DHS website at https://www.dhs.state.il.us/. The customer is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing. Fair hearings result from appeals filed by the customer for adverse decisions that have been rendered. The policies and procedures are compliant with 42 CFR 441.301(c)(7) and ensure the following:

- No punitive or retaliatory action is taken against a customer filing a grievance or an authorized representative.

- The OA will review resolutions for which a customer is dissatisfied
- No conflict of interest with individuals who make decisions on grievances
- The process provides the customer with the opportunity to present evidence and testimony either face-to-face or in writing
- The OA will provide the customer with their case file, other documents, or evidence related to or considered in reviewing the grievance at no cost to the customer
- The OA will maintain grievance records including: description of reason for grievance, date received, date of each review, resolution of grievance, date of resolution, and name of customer

Illinois Department of Human Services - Division of Rehabilitation Services (DHS/DRS) serves as the Operating Agency (OA) for the Home Services Program (HSP), an HCBS waiver program authorized under Section 1915(c) of the Social Security Act. This OA addendum describes the DRS process used to receive, track, review, and resolve grievances/complaints in accordance with 42 CFR 441.301 and applicable state rules (including 89 Ill. Adm. Code 676.30).

DRS uses the term "complaint" consistent with the federal definition of "grievance" at 42 CFR 438.400(b), to avoid confusion with labor-related grievance procedures under collective bargaining agreements. Complaints may include dissatisfaction regarding actions or inactions by DRS staff or waiver service providers, including quality of care or services, interpersonal concerns (e.g., rudeness), failure to respect customer rights, concerns related to person-centered planning and service plan implementation, and issues connected to HCBS settings compliance. Complaints do not replace appeal rights, and matters that meet the definition of an adverse benefit determination (denial, reduction, or termination of services) are handled through the DHS Bureau of Administrative Hearings appeals process.

A complaint may be filed at any time, either orally or in writing, by the HSP customer or an authorized representative. Customers may submit complaints via telephone, mail, fax, or email. When needed, DRS provides assistance to customers in completing complaint forms and navigating the process, and ensures accessibility for individuals with disabilities and individuals with limited English proficiency through reasonable accommodations, including interpreter and translation services.

Upon receipt, DRS logs the complaint and provides written acknowledgement within two business days. Staff then review the complaint, gather and consider information from the customer and/or authorized representative, meet with DRS staff connected to the complaint as appropriate, and evaluate any documentation the HSP customer wishes to submit. If the customer requests access to relevant case file materials, DRS will provide the customer with the case file information, other documents, or evidence relied upon or related to the complaint at no cost, upon completion of the Authorization to Use/Disclose Medical and Confidential Information (IL488-1111W).

DRS ensures that individuals making decisions on complaint resolution have not previously been involved in the complaint or prior decision-making related to it, are not subordinates of such individuals, and have the clinical and non-clinical expertise needed to investigate and resolve the issue. DRS further ensures that all comments, records, and other information submitted by the customer are considered, regardless of whether the information was submitted previously.

DRS resolves complaints and provides notice to the customer, as expeditiously as the customer's health condition requires, but no later than 90 days after receipt of the original complaint. DRS may extend resolution timeframes by up to 14 calendar days when requested by the customer or when DRS documents a need for additional information and that the delay is in the customer's interest. If an extension is approved, DRS provides oral notice and written notification within two business days of the determination.
If the customer is dissatisfied with the complaint resolution, the customer may request a second-level review. DRS will route the request to a DRS Bureau Chief (or designee), and the customer will be notified in writing of the outcome of the second-level review within 30 days of the request.

When a complaint is received that should be handled as an appeal, DRS redirects the matter to the DHS Bureau of Administrative Hearings as a request for hearing and notifies the customer in writing. Similarly, when the Bureau of Administrative Hearings receives a request that does not meet the definition of an adverse benefit determination, the Bureau may refer the matter back to DRS for handling through the complaint process. For customers enrolled in managed care, grievances/complaints are handled through the MCO grievance process; when DRS receives an MCO-related complaint, DRS forwards it to the appropriate MCO and provides the customer written acknowledgement.

DRS maintains complaint records and retains copies of all documents sent to and received from customers in the WebCM case management system. At minimum, the record includes the customer name, date received, reason for complaint, date(s) of review, resolution, and date of resolution. DRS uses complaint data as part of ongoing monitoring and oversight and makes data available to HFS and CMS upon request for program monitoring and continuous improvement.

Standardized templates and forms used within the DRS complaint process include: Customer Complaint Letter; Acknowledgement of Customer Complaint Letter; Customer Complaint Extension Notification; Customer Complaint Resolution Letter; Authorization to Use/Disclose Medical and Confidential Information (IL488-1111W); and Provider Complaint Letter. Customers receive complaint process information at initial eligibility determination and at each eligibility redetermination, and provider agencies receive provider-facing complaint process information at enrollment, with instruction to share it with direct care workers.

CONTINUED IN MAIN B OPTIONAL

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

DRS administration is responsible for ensuring that all Critical Incident Reports (CIR) are processed within timeframes established by the OA and in a manner appropriate for the critical incident. Immediately, or no later than 24 hours, upon receipt of an unusual incident report, it is shared with the designated unit within DRS that is responsible for coordinating these investigations. The OA's Fraud Unit staff determine whether the incident includes abuse, neglect, or financial exploitation, and if so, the Adult Protective Services is immediately contacted. Additionally, the OA will determine whether immediate agency action is required by the OA to assist the customer. If so, the HSP Rehabilitation Counselor is provided with specific instructions on any actions to pursue on behalf of the customer. Any direction received from Adult Protective Services is also acted on immediately by the OA and HSP Rehabilitation Counselor. Throughout this process, OA's Fraud Unit staff work directly with DRS central office staff as well as the local HSP Rehabilitation Counselor in order to ensure proper resolution. As a result, a high level of interaction is maintained on an ongoing basis by administrative and field staff.

Customers under the age of eighteen:

The Abused and Neglected Child Reporting Act - ANCRA (325 ILCS 5) sets forth the requirements for reporting and responding to situations of abuse and neglect against children under the age of 18.

The types of Critical Incidents (CIs) that must be reported include any specific incident of abuse or neglect or a specific set of circumstances involving suspected abuse or neglect, where there is demonstrated harm to the child or a substantial risk of physical or sexual injury to the child. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

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

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

DCFS Hotline Numbers:
1-800-25-ABUSE or 1-800-252-2873 (voice)
1-800-358-5117 (TTY)

Customers age 18 and older

Adult Protective Services (APS)

The processes defined under Adult Protective Services (APS) are the same whether the waiver customer receives care coordination through the state or through managed care.

Public Act 94-1064 amended the Elder Abuse and Neglect Act, changing the name of the entity to Adult Protective Services which had the effect of expanding the former Elder Abuse program to include adults with disabilities (age 18 and older) and adults that are over age 60. In addition, the Adult Protective Services Act (320 ILCS 20/1 et seq.) authorized the Illinois Department on Aging (IDoA) to administer the Adult Protective Services unit (APS) to respond to reports of abuse for all non-institutionalized adults that meet this criteria. The empowered APS unit provides investigation of allegations and intervention and follow-up services to victims. It is coordinated through contracted agencies located throughout the state and designated by the Area Agencies on Aging (AAA) and Illinois Department on Aging (IDoA). The APS agencies conduct investigations, establish substantiation decisions, develop plans to mitigate the

abuse and provide continued monitoring of cases of allegations of abuse. Customers can report suspected abuse, neglect or exploitation to IDoA by utilizing the APS Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week.

Definitions of Abuse, Neglect and Exploitation (ANE)

The definition of abuse pertains to Illinois residents living in a domestic setting who are over 18 years and have a disability or any adult age 60 years or older. The abuse must be one of the following types and must be committed by another person.

The State uses a set of definitions for CIs covering abuse, neglect, exploitation and other events that can place an adult at risk. These definitions can be found at 89 ILAC Section 270.210.

The APS responds to the following types of abuse:
- Physical abuse means inflicting physical pain or injury upon an adult
- Sexual abuse means touching, fondling, intercourse, or any other sexual activity with an adult, when the adult is unable to understand, unwilling to consent, threatened or physically forced.
- Emotional abuse means verbal assaults, threats of maltreatment, harassment or intimidation.
- Confinement means restraining or isolating an adult, other than for medical reasons.
- Passive neglect means the caregiver's failure to provide an adult with life's necessities, including, but not limited to, food, clothing, shelter or medical care.
- Willful neglect or deprivation means deliberate denial of an adult medication, medical care, shelter, food, a therapeutic device, or other physical assistance and thereby exposing that person to the risk of physical, mental or emotional harm- except when the adult has expressed capacity to understand the consequences and intent to forego such care.
- Financial exploitation means the misuse or withholding of an adult's resources by another to the disadvantage of the adult person, or for the profit or advantage of someone else.

A substantiated case means a reported case of alleged or suspected abuse, neglect, financial exploitation, or self-neglect in which an APS agency, after assessment, determines that there is reason to believe abuse, neglect, or financial exploitation has occurred.

State regulations covering APS, mandated reporting, and timelines are contained in 89 Illinois Administrative Code (ILAC), Part 270.

Reporting

More information and brochures [Adult Protective Services Act and Related Laws and What Professionals Need to Know] may be found at: http://www.illinois.gov/aging/ProtectionAdvocacy/Pages/abuse.aspx

Mandated Reporters

The Illinois Adult Protective Services Act (320 ILCS 20/1) requires personnel of the Operating Agency (OA) and Managed Care Organizations (MCOs) to be mandated reporters in all cases of suspected or alleged abuse and/or neglect of a child, adult or elder, as the abuse and/or neglect becomes known to the employee in his or her professional or official capacity. Staff are mandated to personally report the allegations of abuse, neglect and financial exploitation to APS within 24 hours. IDoA's Office of Adult Protective Services maintains a tracking system of ANE investigations and statistical reports are generated annually. Mandated Reporting and timelines for reporting can be found at: 89 ILAC, Section 270.230.

Reporting Timelines

Follow-up Actions by IDoA can be found at: 89 ILAC, Section 270.240 Intake of ANE Reports
Rules may be accessed at IDoA's website at:
http://www.illinois.gov/aging/AboutUs/Pages/rules-main.aspx

When OA staff is made aware of any allegations of Abuse, Neglect or Financial Exploitation, they must take the following actions:
1. Report the suspected abuse, neglect or financial exploitation to the APS by calling the statewide 24-hour APS Hotline at 1-866-800-1409, 1-888-206-1327 (TTY)
2. Alert local authorities, if necessary.
3. Complete a Critical Incident (CI) Report in the Case Management System, including a concise summary of the incident, including significant customers and their relationships.
4. Home Services Program (HSP) Rehabilitation Counselors and Supervisors must be informed immediately of any APS report received and CI Report submitted, so everyone is aware of the incident.

When notified of an APS investigation, the OA's Central Support office enters information into a database for abuse, neglect, incidents, and complaints. The OA's Central Support notifies appropriate field staff, and monitors field activity. Should the allegation be substantiated, the field office is notified, and appropriate action is taken.

Other CIs including those resulting in death or injury not related to ANE:

If the OA Rehabilitation Counselors are made aware of the incidents, they are reported to the central office and an OA Rehabilitation Counselor is assigned to the case. OA Rehabilitation Counselors assist with reporting and remain involved in the case to ensure the customer is safe from harm and that an adequate Person Centered Plan (PCP) is in place to address the customer's needs.

Reports may be generated by the OA that can be tailored to meet specific data needs. Information gathered on the database includes customer demographic data, alleged perpetrator information, incidents of alleged or substantiated abuse and neglect, involvement from the Office of Inspector General or the IDoA, action taken by the OA, and outcome information. These reports are shared on a quarterly basis with the MA.

For customers enrolled in an MCO, the MCOs will have processes and procedures in place to receive reports of CIs. The MCOs shall comply with the Department of Human Services Act (20 ILCS 1305/1-17), the Adults with Disabilities Domestic Abuse Intervention Act (20 ILCS 2435), Elder Abuse and Neglect Act (320 ILCS 20/1) and the Abused and Neglected Child Reporting Act (325 ILCS 5/4). The MCO shall have a formal process for reporting incidents that may indicate abuse, neglect or exploitation of a customer.

The MCOs must comply with the OA's critical incident reporting requirements.

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 into 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.

The MCOs will continue to provide the customer, or their family or representatives, information about their rights and

protections, including how they can safely report an event and receive the necessary intervention or support.

Also, the MCOs will assure that HCBS waiver agencies, vendors and workers (including Care Coordinators) are well informed of their responsibilities to identify and report all CIs. Responsibilities are also re-enforced through periodic training.

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

Upon initial eligibility determination, and subsequent redetermination of eligibility, customers are informed of their rights and responsibilities, including their right to be free from abuse, neglect, and exploitation. Information is shared on whom to notify if abuse, neglect or exploitation occurs. All waiver customers must review and sign the Home Services Program (HSP) Application and Redetermination of Eligibility Agreement. The contents of this document are thoroughly explained to the customer.

As indicated above, customers have discussions about abuse, neglect, and exploitation with the Operating Agency (OA) HSP Rehabilitation Counseling staff at initial enrollment and annual redetermination.

Training specific to abuse, neglect and exploitation is not provided, but the OA does educate customers on those topics. At the time of application and at each redetermination of eligibility, the HSP Rehabilitation Counselors inform customers of their right to be free from abuse, neglect and exploitation and whom to contact for help or to report concerning activity. All waiver customers must review and sign the HSP Application and Redetermination of Eligibility Agreement which contains necessary information about reporting abuse, neglect and exploitation. The contents of this document are thoroughly explained to the customer.

MCOs must comply the Abused and Neglected Child Reporting Act, the Elder Abuse and Neglect 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, 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.

Through an ongoing basis, the MCO must identify, address, and seek to prevent the occurrence of abuse, neglect, and exploitation. Performance Measures regarding health, safety, welfare, and critical-incident reporting are included in the MA contract. Customers are provided information about how and to whom to report abuse, neglect and exploitation during assessments and reassessments. This happens at least quarterly, during face-to-face assessments.

The MCO must train all of their external-facing employees on ANE and critical incidents. This includes network provider and subcontractors, who must be able to recognize potential concerns related to abuse, neglect, and exploitation. MCOs must also train those entities on their responsibility to report suspected or alleged abuse, 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. MCOs train members, and family members about the signs of ANE and what to do if they suspect ANE. 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.

For customers under the age of 18:

The Department of Children and Family Services (DCFS) is the state agency that is responsible for conducting investigations of child maltreatment and arranging for needed services or protective plan as appropriate, for children and families where credible evidence of abuse or neglect exists. DCFS provides protective services at the request of the subjects of the report, even when the report has been unfounded.

DCFS field office staff are required to make initial contact and start the investigation of the allegation within 24 hours of the hotline report. If there is a possibility that the family may flee or if the immediate well-being of the child is endangered, an investigation will start immediately.

Most investigations are conducted in 60 days unless there is just cause for a 30 day extension in order to make a determination whether the allegation is indicated or unfounded. Appropriate emergency services are provided while the investigation is pending. Emergency and ongoing services may include safety plans, protective plans, family support or protective custody, which places the child in substitute care.

Serious allegations such as sexual abuse, serious physical harm, or death are reported to the local law enforcement agency, the State's Attorney, and to the Child Advocacy Center, if available, as a coordinated approach to the investigation. The approach includes victim sensitive interviewing of the alleged child victim(s) and identification and prosecution for a criminal act. DCFS uses a Child Endangerment Risk Assessment Protocol (CERAP) to assess safety of the child. The interview process includes an assessment of the alleged victim's immediate safety. Safety plans can include voluntary removal of the alleged perpetrator or of the alleged victim. If the family refuses to establish a safety plan to control for the threats of danger to the alleged victims, then the child is removed. DCFS staff conduct face-to-face monitoring and reassessment every five days until the child is determined to be safe in the home.

A protective plan is enforced in out-of-home settings, such as daycares and residential settings. The protective plan restricts accessibility of the perpetrator to the child, and it stays in place until the investigation is completed. If the investigation determines that an abuse or neglect situation is indicated, license revocation or remediation activities begin. Monitoring is conducted weekly by investigators and licensing staff until resolved.

If a finding is indicated, the perpetrator's name is placed on the DCFS State Central Register for a minimum of five years, 20 years if there was serious physical injury, and 50 years in cases of sexual penetration or death. If a finding is unfounded, the name is on the DCFS State Central Register for a minimum of 30 days up to three years depending on the seriousness of the situation.

Customers Age 18 and Older:

Adult Protective Services (APS), operated under the Illinois Department on Aging (IDoA), receive and investigate all reports of Critical Incidents (CIs) that involve Abuse, Neglect and Exploitation (ANE). Customers, family members and others may call the State's Senior Helpline: 1-800-252-8966 or the 24-Hour Adult Protective Services Hotline at 1-866-800-1409 to report an allegation of ANE.

The HSP Rehabilitation Counselor, the Operating Agency (OA) and the Managed Care Organization (if customer is enrolled in an MCO)are notified of incidents via a Report of Substantiation produced by APS. Depending on the nature of the incident of ANE, the customer and/or family members, and providers may be notified. The State has set criteria regarding when notifications are mandatory or when they are at the discretion of the HSP Rehabilitation Counselor.

IDoA 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 ILAC Section 270.240

Responding to Reports -
Depending on the nature and seriousness of the allegations, a trained APS caseworker makes a face-to-face contact with the alleged victim within 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.

•Priority Two - Reports that an alleged victim is being abused, neglected, or financially exploited and the report taker has reason to believe that the health and safety consequences to the alleged victim are less serious that priority one reports. The caseworker must make a face-to-face visit within 72 hours.

•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 that 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.

The APS requires that all Priority I incidents be at least temporarily corrected within 24 hours and a permanent correction must occur within 60 days. All other events must be corrected within 60 days. The State's Office of Adult Protective Services' regulations also require certain response timelines by the ANE agency. These are located at 89 ILAC Part 270.

The Event Reporting system within the OA tracks the status of any investigation and follow-up actions taken. The State has established criteria regarding when the HSP Rehabilitation Counselor must conduct a review, when an on-site visit must occur, and when the change of status redetermination must occur.

NOTE: the MCO contract does not dictate when a review or onsite must occur when a CI has been substantiated. The contract does indicate that the MCO will comply with the decision APS has made and will take appropriate action for the customer within the timeframe APS has given. Per APS policy, once a case has been substantiated and the customer agrees to APS services, the MCO Care Coordinator will consult with APS within 20 calendar days. Within that time, the MCO will work with both APS and the customer, review and, if applicable, update the current person-centered care plan to reflect customer needs.

MCOs maintain an internal reporting system for tracking, reporting, and responding to Critical Incidents and for analyzing an event to determine what changes are needed.

The state is responsible to ensure the health and welfare of the customer and may authorize additional services to protect the welfare of the customer. The APS case worker will contact the victim and work with the OA or the MCO care coordinator to help determine what services are most appropriate to stop the abuse, neglect, or financial exploitation. Those services may include:

- in-home or other health care;
- nutrition services;
- adult day services;
- respite care for the caregiver;
- housing assistance;
- financial or legal assistance and protections, such as representative payee, direct deposit, trusts, order of protection, civil suit or criminal charges;
- counseling referral for the victim and the abuser;
- when needed, guardianship proceedings or long-term care placement;
- emergency responses for housing, food, physical and mental health services.

The MCOs are expected to provide any services that APS recommends that fall within MC coverage, and refer for services outside MC coverage (housing assistance, for example).

CIs may also result in a review of the customer's needs to determine whether a change in the service or level of service is needed. A determination may also be made on whether intensive care coordination is needed. MCOs must follow up on Critical Incident outside those determined ANE to ensure information was reviewed and corrective measures were taken. Resolution or remediation is based on the nature of the concern. MCOs must submit a Critical Incident Detail Report (sent monthly) and a Critical Incident Summary report (sent quarterly) to HFS; Critical Incidents for the HCBS waiver population are broken out by waiver population.

APS Reporting

State requirements for reporting of abuse, neglect or financial exploitation of customers age 60 years and older are as follows:

The OA's Office of Adult Protective Services administers the ANE Program, which responds to alleged abuse, neglect or financial exploitation of persons 60 years of age and older who reside in the community. The program provides investigation, intervention and follow-up services to victims. It is locally coordinated through contracted statewide agencies designated by the Area Agencies on Aging (AAA) and IDoA. The APS agencies conduct investigations and work with older adults in resolving abusive situations.

Abuse Hotline Number:

866-800-1409 (voice): available 24 hours a day, seven days a week
888-206-1327 (TTY)
Senior HelpLine number, 1-800-252-8966, during regular business hours. After-hour and weekend calls are automatically transferred to the Abuse Hotline number.

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

Immediately upon receipt of the Notification of Investigation from the Adult Protective Service (APS), the Operating Agency (OA) Fraud Unit forwards the notice to the appropriate OA field office for follow up. The OA Fraud Unit maintains a database in order to track response by the field office.

Critical Incident (CI) Reporting is now completed electronically. Critical Incident (CI) Reports should be completed for situations that are unusual in nature. These include, but are not limited to customer incidents, staff/customer related incidents, and Individual Provider (IP)/customer issues. All OA CIs Reports are entered on WebCM, the virtual case management system, as soon as the OA staff becomes aware of an issue. CI issues may require additional follow up by e-mail or telephone call. The purpose of the CI Report is to alert the chain of command, up to and including the OA Director, promptly of issues such as those listed above so his/her office can quickly alert the OA Secretary and immediate staff about issues. CI reports are reviewed and discussed by the Medicaid Agency (MA) and OA at quarterly Quality Assurance meetings.

Reports are completed the same day of the incident. All reports are reviewed daily and distributed to the appropriate source for follow up. Follow up may be on the specific incident only or may require alerts or directions to all Home Services Program (HSP) staff for program wide changes aimed at preventing reoccurrence. As statutorily mandated reporters, OA staff are also required to refer all incidents regarding abuse, neglect and/or financial exploitation to the statewide 24-hour Adult Protective Services Hotline. The OA will follow up with the field staff on all reports which deal with abuse, neglect or financial exploitation." If an incident involves someone under the age of 18, the Department of Children and Family Services is contacted.

In addition, the OA Fraud Unit works with the local OA field office staff to ensure proper resolution. Critical Incidents are monitored by HSP administration on an ongoing basis. Data is reviewed for analysis and to determine if there are any trends or issues requiring further investigation.

The APS Unit shall initiate an assessment of all reports of alleged or suspected abuse or neglect within 7 calendar days after the report. Reports of exploitation shall be assessed within 30 calendar days after the report is received. Reports of abuse or neglect that indicate that the life or safety of an adult with disabilities is in imminent danger shall be assessed within 24 hours after the receipt of the report. When the APS determines that a case is substantiated, it shall refer the case to the appropriate OA's office or to the appropriate Managed Care Organization (MCO) to develop, with the consent of and in consultation with the adult with disabilities, a Person Centered Plan (PCP) to address the person's needs.

The OA Fraud Unit contacts appropriate field personnel to request follow up on an allegation and request an update on attempts to resolve the situation. Field personnel indicate whether or not an internal investigative review has been completed and the results of that review; and/or if external agencies were contacted for assistance such as the Office of Inspector General, the local police, the DHS Divisions of Mental Health or Developmental Disabilities, etc. All information gathered from these sources is entered into the Critical Incident portion of the customer's case within WebCM.

All information is gathered and stored in the customer's case file, including written, faxed, e-mailed information, case notes, etc. In addition, CI reports are submitted by the field, with intake and final reports from the APS being entered into the OA's Critical Incident database. This information is confidential and is retained for monitoring purposes. The data is reviewed to determine if there are trends or patterns, and if there are situations that need additional investigation or follow up. When warranted, further investigation is pursued. Information stored in the database helps to prevent recurrence of incidents involving the same customer and an alleged offender.

Additionally, the database is used as a reference for investigation of grievances, unemployment claims, and fraud allegations. Together field personnel, administration, APS, and the OA Fraud Unit work together to resolve and prevent the incidence of ANE. These activities are completed on an ongoing basis, and investigation is not complete until resolved by the APS.

For customers enrolled in an MCO, the MCOs will maintain an internal reporting system for tracking the reporting and response to CIs. CI reporting will be included in the reporting requirements to the MA. The MA monitors both compliance of performance measures and timeliness of remediation for those waiver 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 State does not authorize the use of restraint or seclusion in the waiver program. Any allegations of restraint, seclusion, or other potential abuse, neglect, or financial exploitation would be reported to Operating Agency administration via the unusual incident report procedure. Simultateously, an alleged incident would be reported to the proper authority for review.

  For customers enrolled in an Managed Care Organization (MCO), the MCOs are responsible to detect the unauthorized use of restraint or seclusion. Events involving the use of restraint or seclusion would be reported to the MCO as a reportable incident, and reported to the investigating authority as indicated.

  The OAs and MCOs detect the use of restraints through face-to-face visits and routine contacts with the customer, and through reports by providers, family, or friends-as well as through the analysis of complaints or incidents. The Home Services Program Rehabilitation Counselors or MCO Care Coordinators are responsible for overseeing waiver customers and assuring their health, safety, and welfare.

  (See Appendix G-1 for information about critical event or incident reporting requirements.)

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

The State does not authorize the use of restrictive interventions in the waiver program. Any allegations of restrictive interventions or potential abuse, neglect, or financial exploitation would be reported to the Operating Agency (OA) administration via the Unusual Incident Report procedures. Simultaneously, an alleged incident would be reported to the proper authority for review: the Department of Children and Family Services or the Adult Protective Service Unit of the Illinois Department on Aging.

For customers enrolled in an Managed Care Organization (MCO), the MCOs are responsible to detect the unauthorized use of restrictive interventions. Events involving the use of restrictive interventions would be reported to the MCO as a reportable incident, and reported to the investigating authority as indicated.

(See Appendix G-1 for information about critical event or incident reporting requirements.)

The MCOs and OA detect the unauthorized use of restrictive interventions through face-to-face visits and routine contacts with the customer, and through reports by providers, family, or friends-as well as through the analysis of complaints or incidents. The Home Services Program Rehabilitation Counselors or MCO Care Coordinators are responsible for overseeing 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 Home Services Program Rehabilitation Counselors and the Managed Care Organization Care Coordinators through their regular contact monitor for all activities that appear to fall under abuse, neglect and exploitation. Seclusion would fall under this category. In addition, all providers are trained to monitor similar activities. Reports of abuse, neglect and exploitation, including seclusion are to be made to the Adult Protective Services Unit for investigation.

The MCOs and OA detect the use of seclusion through face-to-face visits and routine contacts with the customer, and through reports by providers, family, or friends-as well as through the analysis of complaints or incidents. The Home Services Program Rehabilitation Counselors or MCO Care Coordinators are responsible for overseeing 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: Number and percent of records where the customer/representative 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 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):
Record reviews, on-site
If 'Other' is selected, specify:

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

Agency		
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level with 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:
G2:# and % of unexplained deaths and substantiated incidents of A/N/E reported to the OA and MCO that were reviewed/investigated within the req. timeframe N: # of unexplained deaths and substantiated incidents of A/N/E reported to the OA and MCO that were reviewed/investigated within the req. timeframe D: Total # of unexplained deaths and substantiated incidents of A/N/E reported to the OA and MCO

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:

Performance Measure:
G3: # and % of deaths related to a substantiated case of abuse or neglect reported to the OA and MCO where approp. actions were taken to address incident N: # of deaths related to a substantiated case of abuse or neglect reported to the OA and MCO where approp. actions were taken to address incident D: Total # of deaths related to a substantiated case of abuse or neglect reported to the OA and MCO

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; OA Reports, APS Substantiated Incidents, DCFS 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:

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**	☑ **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:

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

Performance Measures

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

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

Performance Measure:
G5: # and % of substantiated incidents of confinement (restraint or seclusion [R&S]) reported to the OA and MCO where appropriate actions were taken to address the incident. N: # of substantiated incidents of confinement (R&S) reported to the OA and MCO where appropriate actions were taken to address the incident. D: # of substantiated incidents of confinement (R&S) reported to the OA and MCO.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports, MCO Reports, APS/DCFS Substantiated Incidents

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:
G6: Number and percent Individual Providers who received training on alternative practices to restrictive interventions, including restraints and seclusion. N: Number of Individual Providers who received training on alternative practices to restrictive interventions, including restraints and seclusion. D: Total number of Individual Providers.

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

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

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

Data Aggregation and Analysis:

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

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:
	☐ **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 that they visited a doctor or practitioner for an annual screening within the last 12 months. N: Number of customers reporting that they visited a doctor or practitioner for an annual screening within the last 12 months. D: Total number of customer records reviewed.

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

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

		Sample Confidence Interval = 95% confidence level with 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:

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

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

The Medicaid Agency (MA) will conduct routine programmatic and fiscal monitoring for both the Operating Agency (OA) and the Managed Care Organization (MCO).

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

G2: The OA/MCO will follow up on unexplained deaths and outstanding Adult Protective Service (APS) referrals and DCFS reports of substantiated incidents. Changes in customer's Person Centered Plan (PCP), corrective action plans, or provider sanctions will be made when needed. Remediation must be completed within 30 days.

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

G4: The OA/MCO will review all outstanding critical incidents with the MA to identify trends and implement systemic interventions, which may include training, a plan of correction, or other remediation to assure that critical incidents are being analyzed to determine root cause. Remediation must be completed within 30 days.

G5: The OA/MCO will follow up on all outstanding APS referrals and DCFS reports of substantiated incidents where restrictive interventions were used. 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 the individual provider receives training on alternative practices to restrictive interventions, including restraints and seclusion, within 30 days.

G7: If identifying information is available for customer surveys, the HSP Rehabilitation Counselor, BI Case Manager, or 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 HSP Rehabilitation Counselor or the MCO Care Coordinator will ask whether the customer has a primary care doctor or practitioner and whether the customer 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 HSP Rehabilitation counselor 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:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

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

The MA, OA, and MCO's are responsible for data collection and remediation activities. The OA is solely responsible for eligibility and authorizing qualified providers. Therefore, there are distinct performance measures for these functions under the OA. Both the OA and the MCOs are accountable for all other measures. The MA is accountable for the measures in the Administrative Authority appendix. The State's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the waiver performance measures.

The persons with disabilities waiver Quality Management System (QMS) plan is part of an overall quality management plan for the three 1915 (c) waivers operated by the DHS-DRS (OA). The other waivers include the HIV/ AIDS Waiver (control number IL.0202), and the Brain Injury Waiver(control number IL.0329). While some data may be collected during the same on-site provider and case manager reviews, the sample for each waiver is drawn separately and the results are aggregated separately.

The MA's ongoing quality monitoring includes sharing of reports from QIO reviews with the OA as well and review site, and EQRO reviews with the OA and the MCO.

On a quarterly basis, the MA conducts separate Quality Management Committee (QMC) meetings with the OA and the MCOs to review data collected from the previous quarter and for the year to date. Data is collected on a regular basis and reported as indicated by the performance measures in the waiver.

OA and MCO compliance data is reported by individual performance measures. Data reported includes level of compliance and timeliness of remediation based on immediate, 30, 60, 90 day increments and any outstanding remediation.

During quarterly meetings, the MA, and the OA or MCO will identify trends based on scope, severity, changes, and patterns of compliance by reviewing both the levels of compliance with the performance measures and remediation activities conducted by the OA and the MCOs. Identified trends 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 QMC Systems Improvement 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 their respective logs. 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 will be communicated through the sharing of the quarterly meeting summary and the systems improvement log.

The MA hosts weekly operational meetings with the MCOs. All MCOs are required to attend. Subject matter is based on MCO need or when the MA has identified a need to review.

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**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The processes Illinois follows to continuously evaluate, as appropriate, effectiveness of the QMS are the same as the processes to evaluate the information derived from discovery and remediation activities. The Waiver Quality Management Committee (QMC) System Improvement Log is a dynamic product that is discussed quarterly by key staff of the MA and the OA or MCO regarding progress, updates, and evaluation of effectiveness. Effectiveness is measured by impact on performance based on ongoing data collection over time, feedback from customer/guardian interviews, satisfaction surveys, and service providers. Multiple years of data collection will allow the MA to evaluate the effectiveness of system improvements over time.

System design changes may be specific to the OA, the MCOs, or both. Meeting with all parties annually provides an arena to see the system holistically and determine how well the system design changes are working and what areas need further improvement. Decisions that are made as a result of these meetings will be tracked on the QMC Systems Improvement Log.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

One QMC meeting a year is a combined meeting where the MA, the OA, and the MCOs meet and discuss statewide issues impacting the waiver. During this annual meeting, the OA and the MCOs will provide an overview of the previous year's activities and a discussion of whether changes are needed to the Quality Management Strategy. There will be five primary focus areas: These areas are described below.
1) Structure of the QMC: The group reviews the structure of the QMC to determine if it is effective.
2) Trend Analysis: The group will evaluate the processes for identifying trends and patterns to assure that issues are being identified.
3) Systems Improvement Log: The group reviews the QMC Systems Improvement Log to assure that all recommendations have been implemented in accordance with agreed upon timelines, and if not, whether there is justification.
4) System Improvement Priorities: The methods for determining system improvement priorities is evaluated to determine its effectiveness.
5) Performance Measures: The entities will determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures will also be reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

The MA will continually strive to increase the compliance rate of each performance measure. While the target compliance rate for each performance measure is 100%, the State realizes that it may take multiple system changes over several years to reach the goal of 100% compliance.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Requirements concerning the independent audit of provider agencies:

Department of Human Services, Division of Rehabilitation Services (DHS/DRS) completes a review of each Homemaker and Adult Day Service provider at a minimum of every two years to ensure compliance with program regulations. The compliance review is conducted on all agencies currently enrolled with DHS/DRS for the purpose of determining compliance and/or continued compliance with the Administrative Code: Title 89: Social Services, Chapter IV: Department of Human Services, Subchapter d: Home Services Program, Part 686 Provider Requirements, Type Services, and Rates of Payment. Homemaker and Adult Day Service Agencies are required to engage an independent certified public accounting agency complete an independent audit of their financial statements, and to verify the accuracy of information and data submitted to the OA. This audit will be performed at the Homemaker Agency provider agency's expense.

30 ILCS 5/3 specifies the jurisdiction of the Auditor General and section 3-2 identifies the mandatory post audits. The Auditor General shall conduct a financial audit, a compliance audit, or other attestation engagement, as is appropriate to the agency's operations under generally accepted government auditing standards, of each State agency. In conjunction with HFS' portion of the Statewide Single Audit, a sample of provider billings for Medicaid payments, that may include billings for Medicaid payments for waiver services, are reviewed. The Illinois Office of the Auditor General is responsible for conducting the financial audit program.

i. Per 89 IL Admin Code 686.10, Individual Provider (IP) Requirements, IPs must demonstrate that they meet the required qualifications in several forms which must be signed by the IP and the customer and turned in to the waiver program as the first part of the OA provider enrollment process IPs. This includes the Individual Provider Standards form as well as the Individual Provider Payment Policies form.

ii. On one of these two forms, the Individual Provider Payment Policies, the IP must assure that he or she will provide services in accordance with the customer Person Centered Plan (PCP) which specifies the frequency, amount, and duration of services to be provided. This form also requires the IP to assure that he or she will abide by the limits of service provision as also specified in this section of the Administrative Code.

iii. The waiver program continues to use an Electronic Visit Verification (EVV) system as a means to better ensure that IPs and homemakers, including respite, are in the customer's home at the beginning and end of their work shifts. Personal care services, which are the Activities of Daily Living (ADLs) and the Instrumental Activities of Daily Living (IADLs) are subject to EVV. The existing payment system checks to make sure the customer is eligible at the time of service and the hours billed are within the limits of the customer PCP. Completing forms to use the EVV is another part of OA provider enrollment. The process is similar for Home Health Care Services (HHCS). HHCS subject to EVV are home health aide, in-home shift nursing, intermittent nursing, occupational therapy, physical therapy, speech therapy, and medical supplies that require an in-home visit for set-up. The existing payment system checks to make sure the customer is eligible at the time of service and the hours billed are within the limits of the customer PCP. Completing forms to use the EVV is another part of OA provider enrollment.

At the time of redetermination, there is a visual review of the customer's physical condition and home environment for evidence that the tasks to be performed by the customer's IP have been performed, as well as an interview with the customer regarding his or her satisfaction with their IP using the annual IP Evaluation form.

The waiver also has more systematic ways to check for fraud as it relates to service provision by IPs. For example, the program receives monthly reports which show that IPs may have provided services when a customer was in the hospital or nursing home or after a customer's death. Any indication that the IP is not providing the correct hours of service and performing the correct tasks for eligible customers are followed up on promptly. Any inappropriate payments must be repaid and backed off the Medicaid claim. In addition, where there is indication that IPs have sought inappropriate payments, the OA takes corrective actions up to and including preventing the IP from providing any future services in the program.

Agency scrutiny is triggered in several situations, including where there are complaints about no-show homemakers and when IPs bill for more services than are on the PCP. In addition, agency scrutiny is triggered based on reports the OA gets on totals paid to the agencies. If the reports do not match the information being sent by agency administration, the OA knows that the information may be inaccurate. The OA has also noted instances in which agencies have tried double and triple billing for the same month or for the same customer, or when agency bills contain customers that are no longer being served or perhaps were never served. These billings are additional examples of evidence suggesting fraudulent information.

The OA requires independent annual audits in compliance with DHS Administrative Codes Section 686.100 Adult Day Service (ADS) Provider Requirements and Section 686.250 Financial Reporting of Homemaker Service Providers. Adult Day Service and Homemaker providers must provide the licensing agency, Illinois Department on Aging, with an annual audit report to be completed by an independent Certified Public Accountant (CPA) and in accordance with 74 Ill. Adm. Code 420.Subpart D. The audit report shall be filed at the main office of the Illinois Department on Aging, Springfield, Illinois, within 6 months after the date of the close of the provider's business fiscal year. The OA obtains these reports directly from the provider. The OA and the licensing agency, IDoA, also communicates when there are provider compliance issues. A special review may be conducted based on these communications.

The OA also reviews fiscal activity on customer cases as part of the OA overall quality assurance process. Every two years the OA conducts a compliance review of the provider and reviews certain criteria regarding fiscal accountability. All providers are reviewed within the two-year cycle and all reviews are conducted onsite. The review process is the same for both adult day service and homemaker providers. Prior to the compliance review, the OA conducts a preliminary record review to identify red flags. If issues are found, those cases are pulled and reviewed onsite. Examples of red flags include inconsistent attendance or no attendance by customer with conflicting billing data; and billing more than what was authorized by the OA. The number of cases reviewed may vary depending on the number of customers served by the provider. The OA methodology uses a floor of ten cases. If the provider serves fewer than ten customers, all records are reviewed. If more than ten, a 10% random record review is selected with the floor of ten. The period reviewed is based on the previous fiscal year. Lastly, to ensure proper identification of customers and providers, all customers social security numbers are verified for accuracy through the Social Security Administration database, and all providers' employer identification numbers are likewise verified prior to enrollment as a Medicaid provider.

(b) The financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits;

The Medicaid Agency (MA) has implemented oversight procedures that provide assurance that claims are coded and paid in accordance with the reimbursement methodology specified in the waiver. These processes enable staff to monitor the financial aspects of the Persons with Disabilities waiver from a global perspective, rather than review a sample of paid claims. The MA determined that reviewing a sample of paid claims was of limited effectiveness and would not likely disclose problematic billings, patterns and/or trends.

The State has mechanisms in both the MA and OA to recognize whether a provider is a certified biller. The MA has an elaborate IT system which records whether the provider documentation has been received and reviewed and for what period of time the certification is valid. This information then becomes an IT edit for all subsequent financial transactions for this provider for the period that the certification is valid. At the expiration date, no further payments or claims can be made by the MA for this provider until recertification is completed and recorded on the IT system.

The OA has an equally elaborate IT recording and edit system. The MA's certification is also recorded in the OA system along with the OA's own required enrollment information. The OA's EVV timekeeping and billing system for IPs will not take recorded start and stop times until the IP has completed all enrollment information for both the MA and the OA. Without that information, IPs cannot be paid. The fee schedule is posted at http://www.dhs.state.il.us/page.aspx?item=83520.

The MA staff utilizes its 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. The identified exceptions are printed out with all relevant service data. Current exception reports identify paid claims for waiver services to customers who were in a nursing home or who are deceased. MA staff conduct targeted reviews based up on suspicion of fraud or inappropriate billing found in the exception report. Targeted reviews are not based upon a specific percentage or representative sample. The targeted reviews provide a detailed review of services and claims during the timeframe in question of individual waiver services, utilization of waiver services by individual customer, and billing trends and patterns of providers. These targeted reviews are paper based and are not conducted onsite. Targeted reviews do not vary among services. Claims and eligibility information are extracted from the data warehouse and reviewed in detail to determine anomalies is services, claims, billing trends and/or patterns. Death dates are verified to SSA/SSI death dates. Nursing home stays are compared to overlapping waiver services. If inappropriate billing is discovered, the OA is notified. The claim is adjusted or voided by the OA to reduce the state's claim for FFP. The OA will contact the provider to collect any overpayment. In cases of fraud, the HSP Medicaid Fraud Unit contacts the OA who will set up a receivable for any court-ordered restitution. The OA will also void or adjust any claims

related to the restitution.

Continued to Main B Optional

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 Reports, MMIS Medical Data Warehouse

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

☐ ***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:
WebCM, 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 =* *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***

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

b. Sub-assurance: The state 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 Medical Data Warehouse, 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.*

The Medicaid agency (MA) will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs.

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

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

For the administrative claims review, the MA reviews the entire DHS claim to Medicaid administrative costs.

For the waiver claims review, 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 HFS' contracts with 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 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.*

I1: The MA will require the OA to void the federal claim for services provided prior to the customer's waiver enrollment. The MA will adjust the federal claim for services provided by the MCO prior to the customer's 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:*	☐ ***Annually***

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

c. Timelines

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

- ◉ ***No***
- ○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The MA solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the waiver are proposed. The notice 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 guardian (when applicable), family members, providers, stakeholders, and any interested parties.

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 methodology with HFS for its approval. Rates of payment for program services since the initial 1915(c) waiver was approved have been established and updated as described below. The rates are available to the public through the OA's website: https://www.dhs.state.il.us/page.aspx?item=83520.

Historical record of rate increases can be found in previous amendments.

Individual Provider (IP):
An agreement with the Service Employee International Union (SEIU) provides that hourly direct care staff rates receive periodic flat rate adjustments. To develop the rates, rate studies are performed, and Bureau of Labor Statistics information is analyzed to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. The rates were last reviewed in 2026, with approval of the current agreement, which was effective 7/1/23 and ends 6/30/27. In accordance with FLSA regulations, the State also allows for overtime and travel reimbursement to IPs. The rates do not include any direct or indirect administrative costs, are not geographically based, and exclude room and board costs. Rates and labor agreement are available to the public through the SEIU website and the Illinois Central Management Services website: https://cms.illinois.gov/content/dam/soi/en/web/cms/personnel/employeeresources/documents/23-27/Final Signed Agreement SEIU DORS 7.18.24.pdf

IP rate and IP Respite rates effective 7/1/2026 or upon CMS approval are:
IP: $20.00, CNA: $23.00, LPN: $30.00, RN: $36.75
The method of rate determination does not differ between self-directed services or services that are provider managed. Rate increases are consistently applied to both self-directed services or services that are provider managed.

Home Health Extended State Plan and "Other" Services:
This includes In-Home Shift Nursing, RNs, LPNs, intermittent nurse visits, Home Health Aides (HHA), and therapies (OT, PT, and Speech). Rates for State Plan services are reviewed minimally every five years to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program.

Different rates are paid for RNs, LPNs, and HHAs depending on whether the service is provided by a licensed home health agency or by an independently licensed or certified provider. Historically, the independently licensed or certified provider rates were negotiated on an individual customer basis with rate ceilings based on the prevailing wage rates for these providers statewide. Beginning in July 2012, the SEIU contract was expanded to include independently licensed or certified providers using a fixed rate schedule for each type of service. These rates are available to the public through the SEIU website and the Illinois Central Management Services website in the published labor agreement. In accordance with FLSA regulations, the State also allows for overtime and travel reimbursement to home health service providers.

The rate for agency-based providers (RNs, LPNs, and intermittent nurse visits) were last reviewed in 2026. The rates for agency-based providers are not geographically based and do not include room and board. The rate for agency based HHAs was last reviewed in 2026. CNA rates are not geographically based and do not include room and board.

Agency based provider rates effective 7/1/26:
RN $45.00, LPN $37.50, HHA $25.00, Intermittent Nursing Visit $111.00

These rates are based upon the Home Health Fee Schedule:
https://hfs.illinois.gov/medicalproviders/medicaidreimbursement/hhfeeschedule.html

The method of rate determination does not differ between self-directed services or services that are provider managed.

Rate increases are consistently applied to both self-directed services or services that are provider managed.

OT, PT, and Speech Therapy:
State Plan services are reviewed minimally every five years to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. Therapy rates are not geographically based and do not include room and board. The State reviewed the rates for agency-based providers in calendar year 2023 and no increase was implemented. Current rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. In the future, these rates will be reviewed minimally every five years.

Effective 7/1/2026: OT, PT, Speech Therapy rate: $111.00

These rates are based upon the Home Health Fee Schedule:
https://hfs.illinois.gov/medicalproviders/medicaidreimbursement/hhfeeschedule.html

The method of rate determination does not differ between self-directed services or services that are provider managed. Rate increases are consistently applied to both self-directed services or services that are provider managed.

Homemaker:
The homemaker rate is a fixed unit rate based on the rates established by the IDoA in the Elderly Waiver (0143). The rate is based on a fee-for-service structure. Providers are paid on a fixed unit rate per hour of service. This rate is designed to include both administrative and direct service costs. The rates are not geographically based and do not include room and board. The homemaker rate was originally established by requesting information from applicants on their costs for providing the service and the size of the population each applicant projected it could serve.

Homemaker providers are required to expend a minimum of 73% of their total revenues on direct service worker costs. The remaining 27% of revenues may be spent by the provider agencies at their discretion on administrative or program support costs. See 89 IAC 240.2040. Expenses that may be counted as direct service worker costs include wages, health coverage, retirement, FICA, uniforms, workers compensation, travel reimbursement, FUTA, and unemployment insurance. Program support and administrative expenses include direct service worker supervisor costs, training costs, malpractice insurance, administration staff costs, consultant fees, supplies and equipment, telephone service, occupancy costs, and postage per 89 IAC 240.2050. The homemaker rate includes administrative costs and direct care staff wages. The rates are not geographically based and do not include room and board. Homemaker rates are reviewed by IDoA minimally every five years to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. The rate was last reviewed in 2025 and increased 1/1/26.

The Homemaker and Respite Homemaker rates are a blend of the base rate and the enhanced rate of an additional $1.77 per hour/unit paid to agencies who provide health insurance coverage to their employees. The rate reflects a 75%/25% weighting of the enhanced rate and the base rate, respectively.
The In-Home Service (Homemaker) rate effective 7/1/2026 is $30.80 an hour.

The method of rate determination does not differ between self-directed services or services that are provider managed. Rate increases are consistently applied to both self-directed services or services that are provider managed.

Adult Day Service (ADS):
ADS rates are based on rates established by the IDoA in the Elderly waiver (0143). 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 rate calculated independently of the ADS rate. Providers are paid per one-way trip for ADS Transportation. These rates were originally established by legislation.

ADS providers in this waiver are the same as used by the IDoA. They have the same staffing ratios and the same qualifications as the ADS providers used by the IDoA. The rate structure consists of two fixed unit rates, one for ADS and another for ADS transportation (ADST). ADS rates include both administrative and direct care costs. They are not geographically based and do not include room and board. ADS rates are reviewed minimally every five years by IDoA to

ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. The ADS and ADST rates were last reviewed in 2025. The study was conducted by an external vendor to ensure rates were efficient, cost effective, and allowed for the purchase of services at the lowest rate that will ensure access to waiver services by multiple providers. In the rate study, a thorough analysis of ADS and ADST programs was completed. This process included conducting focus groups which included participants, reviewing existing state data, and developing and distributing two provider surveys.

The ADS rate, effective 07/01/2026, is $16.84 an hour.
The ADST rate, effective 07/01/2026 is $12.44 per trip.

Personal Emergency Response System (PERS):
PERS rates are based on the rates established by IDoA in the Elderly Waiver (0143). The State worked with an external vendor to review its rates to determine if the rates are efficient, cost effective and allow for the purchase of services at the lowest rate that will ensure access to waiver services by multiple providers. In developing the rate, the State examined Medicaid reimbursement rates paid in other states, as well as analyzed installation costs incurred by existing contracted and non-contracted providers. The State 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 State will employ a methodology of frequent, ongoing review to ensure that the installation rate remains in line with similarly situated programs in other states and is reflective of the cost of providing the installation service.

CONTINUED IN MAIN B OPTIONAL

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Provider Payment

The operating agency (OA) pays the provider directly. The three-party Medicaid waiver provider agreement is on file with the MA and allows the provider to voluntarily reassign payment to the OA. If a provider chooses to receive payment directly from the MA, the provider will sign the standard Medicaid provider agreement (HFS 1413). Providers may receive payment directly from the MA, if they choose not to voluntarily reassign payment to the OA.

The OA maintains a computerized payment system that includes PCP authorization for each customer, payments to provider agencies, units of service delivered to each eligible customer, and payment and claiming rates per unit of service.

The OA authorizes services in advance of service delivery. Both the provider and the customer report and certify that the service was delivered and the HSP Rehabilitation Counselor approves payment for the service. A combination authorization/voucher document is utilized in this payment process and constitutes a legal agreement between the OA and the provider.

The OA payment system contains edits to ensure that payments are made only when the customer is authorized for the program services delivered, via the PCP that specifies the program services, the provider of the program services, and the amount the services authorized.

OA claims processing
Payments are made by the State of Illinois Comptroller's Office from OA appropriation. The OA then submits the amount of expenditures for Medicaid eligible customers to the MA for submission of federal financial participation.

MA claims processing
The OA waiver claiming data is transmitted to the MA. The MMIS matches the customer against the recipient eligibility file to ensure Medicaid eligibility on the date of service and verifies the provider is enrolled as a waiver provider with the MA. MMIS includes edits for waiver claims that conflict with other waivers, hospitals, nursing home, hospice facilities, or institutional claims, and rejects waiver claims that are duplicative or incompatible. "The State currently operates a compliant EVV system for personal care services in this waiver. The State was approved for a Good Faith Effort exemption request for the implementation of an open/hybrid model Electronic Visit Verification (EVV) on November 21, 2019. On June 3, 2021, the MA posted a Request for Proposal (RFP) to secure the open/hybrid model Electronic Visit Verification (EVV). This system will be used for all personal care services. Customers have the choice to continue to use the current EVV system operated by the OA or change to the open/hybrid EVV model system that will be maintained by the MA."

The MA pays the MCOs a monthly capitated rate for waiver services.

This payment is generated from MMIS based on customer eligibility for waiver services. Waiver providers receive payment for services by billing the MCOs on a timely basis. The MCOs issue payments based on claims received and verification of individual customer waiver eligibility. These claims paid by the MCO are then submitted to the MA as encounter data.

Provider rates may be viewed at this link: http://www.dhs.state.il.us/page.aspx?item=83520

The State currently operates a compliant EVV system for personal care services in this waiver. The State was approved for a Good Faith Effort exemption request for the implementation of an open/hybrid model Electronic Visit Verification (EVV) on November 21, 2019. On June 3, 2021, the MA posted a Request for Proposal (RFP) to secure the open/hybrid model Electronic Visit Verification (EVV). This system will be used for all personal care services. Customers have the choice to continue to use the current EVV system operated by the OA or change to the open/hybrid EVV model system that will be maintained by the MA.

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:*

Individual Provider and agency billings are validated by the OA and MCOs to verify the effective date of the customer's authorization for services are rendered according to the approved PCP. Customers also sign time sheets for Individual Providers to verify that services were performed in accordance with the PCP. Currently, the OA requires both paper timesheets and Electronic Visit Verification (EVV). The OA is working toward eliminating timesheets and using EVV only. For services that do not require a timesheet or the use of Electronic Visit Verification (EVV), the agency provider submit bills directly to OA local offices and the MCOs for processing. OA local office staff verify that the customer was eligible on the date of service, services were rendered in accordance with the authorizations and the PCP. The MCOs billing system performs checks to ensure services are rendered in accordance with authorizations for services and the PCPs. Service delivery for both IPs and agency workers is comparing EVV records with the services authorized and services included in the customer's PCP, as well as through communication with customer. Verification of service provision is also monitored by OA HSP Counselors and MCO Care Coordinators during contact with the customer to determine if services are being received by the customer as authorized and detailed in PCP. When inappropriate claims are identified, the OA and MCOs work with the provider to correct their billing. Voided claims reduces the state's claim for FFP through an adjustment process. If the correction includes a recoupment, the collection occurs through future billings submitted by the provider until the money is recouped. If a correction can't be made by recoupment, the OA submits a request to the DHS, Bureau of Collections (BOC) to establish a collection. The BOC works with the provider until the debt is collected. The system has edits in place to adjusts billings to ensure they don't get submitted for FFP. The MCOs follow their collection processes.

Monthly capitated rates are paid by the MA to the MCOs. 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 customers eligible for waiver services. The MCO payment process is automated to generate a monthly capitation 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 any discrepancies to the MA.

The MA has a monthly capitation program that uses the MMIS Recipient Database to determine who is enrolled with a particular MCO. The program includes logic that uses customer eligibility criteria to determine the appropriate rate cell to be used in generating the payment. As a result of this process, a file is created of MCO schedules which are then sent on to the Comptroller for payment. Once the payment has been made by the Comptroller, a file is sent back to HFS by the Comptroller that includes a warrant number and date. HFS then creates a HIPAA 820 files for each MCO. The 820 file contains the detailed payment information on each of the MCO's enrollees.

The MCOs are required to have internal processes to validate payments to waiver providers. The MCOs claims processing system must verify a customer's waiver eligibility prior to paying claims.

Post-payment PCPs and financial reviews are also conducted, to ensure that PCPs are consistent with needs identified in customer's assessments.

The State is not currently leveraging our EVV vendor for pre-payment review program for PCS and/or HHCS.

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 OA makes payments from a central computer system. Claims are edited and then sent to the MA for further editing and for Medicaid claiming. The audit trail is established through state agency approved rates, PCP authorizations, documentation of service delivery, and computerized payment, and claiming systems cross-matched with the MMIS.

Monthly capitated rates are paid by the MA to the MCOs. 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 customers 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 OA.
The OA explains to providers that the waiver agreement voluntarily reassigns payment responsibility to the OA and that they have the option to bill the MA, directly, if they choose.
The provider signs the three-party Medicaid provider agreement that allows voluntary reassignment of pay. The OA makes payments directly to providers of waiver services and certifies those expenditures to the MA.

Illinois has developed a state operated payroll system for IPs. The customers must sign service calendars to verify the hours worked. The IP sends the hours worked to the OA for review and approval. The OA enters the payment into the WebCM, the OAs virtual case management system. WebCM includes internal edits to assure that the correct rates and the claims are within the service cost maximum. The OA operated payroll system pays IPs twice monthly. The payroll system withholds unemployment, FICA, union dues and other deductions as requested by the IP.

Services - The OA passes the detail expenditure data once a month to the MA. The MA is the Single Statewide Medicaid claiming agency for the State of Illinois. The data is fed into the Medicaid Management Information System (MMIS) and is subject to edits to ensure the information provided is accurate and that the services/providers are eligible for federal match under Title XIX. Should any claims have inaccurate information, those claims are rejected by the system and a file of the rejected claims is passed back to the OA for their review. Claims that pass through the system without error filter down to the MARS reporting unit. The MARS unit is responsible for generating the reports to the Bureau of Federal Finance (BFF) who use the reports to claim Medicaid expenditure data quarterly on the CMS 64. MARS also has a series of edits and codes that are used to filter data to ensure accuracy and to determine to what program the expenditure should be reported. The BFF report the expenditures on the CMS 64 on a quarterly basis 30 days after the quarter ends.

Federal Draws from the Medicaid Grant - In accordance with the Cash Management Improvement Act (CMIA), the BFF draws down federal monies from the Title XIX grant for the waiver on a weekly basis and deposits the funds into the General Revenue Fund (GRF). The amount to be drawn is an estimate derived by using historical expenditure data. Once the CMS 64 is completed at the end of the quarter, 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.

The MCOs are responsible for paying for all waiver services, as specified in the MCO contract. There are no waiver services not covered by the MCO contract.

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.

The only service that will have an enhanced rate is Homemaker (in-home service). This payment is only for in-home service provider agencies that provide health insurance. The source of the non-federal share of the enhanced payments would be the State of Illinois. Each service provider that receives the enhanced rate will retain 100% of the total computable expenditure claimed by the Medicaid Agency to CMS. With the public notice and the continuous posting of the rate increase on the HFS website, it is believed that the public is fully aware and that the intent is clear as to which providers are eligible for the enhanced payment.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

Department of Human Services-Division of Rehabilitation Services

ii. Organized Health Care Delivery System. *Select one:*

- ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ***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 operating agency receives the non-federal share through the General Revenue Fund appropriations.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

● ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

● ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	*Col. 2*	*Col. 3*	*Col. 4*	*Col. 5*	*Col. 6*	*Col. 7*	*Col. 8*
Year	*Factor D*	*Factor D'*	*Total: D+D'*	*Factor G*	*Factor G'*	*Total: G+G'*	*Difference (Col 7 less Column4)*
1	*32620.18*	*16933.31*	*49553.49*	*72510.54*	*17620.63*	*90131.17*	*40577.68*
2	*35990.10*	*18102.70*	*54092.80*	*77071.75*	*18993.29*	*96065.04*	*41972.24*
3	*39482.80*	*19257.26*	*58740.06*	*81485.85*	*20373.20*	*101859.05*	*43118.99*
4	*43421.61*	*20545.39*	*63967.00*	*86375.00*	*21917.69*	*108292.69*	*44325.69*
5	*47770.01*	*21927.99*	*69698.00*	*91557.50*	*23588.98*	*115146.48*	*45448.48*

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	*38886*	*38886*
Year 2	*41283*	*41283*

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 3	*43830*	*43830*
Year 4	*46534*	*46534*
Year 5	*49404*	*49404*

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.*

Projections for the waiver period are developed based off of enrollment trends observed in the Enterprise Data Warehouse (EDW) for the Persons with Disabilities waiver between January 2021 and December 2025. New entrants for the five-year waiver period are projected at 1.65% of monthly enrollment, while members leaving the waiver are projected at 1.15% of monthly enrollment, making net enrollment growth approximately 0.5% monthly.

The Continuing Recipients reflect the current enrollment for the existing waiver trended forward to July 2026 using the net enrollment growth of 0.5% identified above. The Unduplicated Count cumulatively adds the Continuing Recipients and Phase-In participants. The average length of stay (ALOS) estimate for each waiver year is equal to the projected total number of days participants will be enrolled in the waiver divided by the unduplicated participant count.

The higher ALOS in WY 1 and 2 may be related to the public health emergency (PHE). A relatively stable ALOS has been observed since WY 3 and therefore stability is assumed throughout the waiver renewal 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:*

Factor D is the average annual per capita cost for waiver services for waiver participants. For services with credible experience, the State developed estimates using state fiscal year (SFY) 2025 claims experience from the Medicaid Agency's (MA) enterprise data warehouse (EDW) and the Operating Agency's (OA) invoices. The State limited experience to:

- Members with Medicaid eligibility and an open Persons with Disabilities waiver SpecialEligCd segment.
- Claims identifiable by a Persons with Disabilities waiver service procedure code.

#Users
To estimate the number of users for services covered under the waiver, we summarized the number of users of each service during the base period for waiver members. For each WY, we adjusted the number of users of each service to reflect the WY's average length of stay. This results in higher number of users in WY 2 (12 months ending June 2028) because this time period has an extra day due to a leap year. In addition, we assumed a minimum of ten users of each waiver service, rounded to the nearest user.

Avg Units per User
To estimate the average units per user for services covered under the waiver, we summarized experience from the base period of the waiver. Some services have inconsistent or illogical unit reporting, particularly for MCO encounters. We adjusted unit counts in the data to align with the appropriate unit type (e.g., hourly) in the filed waiver.

For services without known data issues, we estimated average units per user using unadjusted SFY 2025 experience. We applied a missing data adjustment of approximately 5.0% to the encounter data to account for differences between submitted encounter data and MCO financial reporting. When composited with the unadjusted FFS and invoice data, the missing data adjustment increased factor D estimates by approximately 0.6%.

For each service, we trended SFY 2025 average units per user to the midpoint of each waiver year (January 1 for each WY). We reviewed waiver trend analysis used in CY 2025 and CY 2026 HealthChoice capitation rate development and selected reasonable trends based on observed utilization patterns. An annual utilization trend of approximately 3.0% was applied to services with data primarily received on DRS invoice files. An annual utilization trend of approximately 5.0% was applied to services primarily received from the EDW.

Avg. Cost/Unit
To estimate average cost per unit of each service, we trended the base claims reimbursement to the midpoint of each waiver year.
Trend Assumptions
The following assumptions were used for trend development:
• Individual Providers (Personal Assistant, Home Health Aide Independent (CNA), In-Home Shift Nursing RN Independent, In-Home Shift Nursing LPN Independent) trends were developed based on the average annual reimbursement change between January 1, 2024 and January 1, 2026.
o Agency providers (RN, LPN, CNA) and Intermittent Nursing: Trends are equal to their independent counterparts. Multi-customer nurse and Intermittent Nursing trends are consistent with RN trends.
• Adult Day Care, Adult Day Care Transportation, and Homemaker trends were developed based on the average annual reimbursement change between January 1, 2023 and January 1, 2026.
• Respite services: Trends are equal to their non-respite counterparts.
• Environmental Accessibility Adaptations, Specialized Medical Equipment, and Personal Emergency Response Systems Monthly Monitoring and Install: Trends equal approximately 2.8%, which is consistent with the annualized change in the Producer Price Index (PPI) for Medical Equipment and Supplies between November 2023 and November 2025.
• Occupational, Physical, and Speech therapy: Trends assumed to be 0.0%. We considered historic Medicaid fee schedule changes and Medicare PT/ST/OT reimbursement trends.

For services with little to no experience in the base period, we assumed a minimum of 10 users per service and one unit per user. We based these assumptions on conversations with CMS, during which CMS indicated that incorporating additional conservatism into waiver estimates was appropriate to help limit the need for amendments.

To evaluate credibility, we reviewed year-to-year variations in experience. Services with little to no experience were considered not credible. Services with limited or highly variable experience were reviewed on a case-by-case basis to assess reasonableness. To assess whether a service had credible experience, we used 372 reports covering the 12-month periods ending June 2023 (with data received through October 2024) and June 2024 (with data received through October 2025). These sources were evaluated alongside the base data, defined as the 12-month period ending July 2025 with data received through January 2026.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is the average per capita state plan service cost for waiver participants. To estimate costs in the Persons with Disabilities waiver, the State stratified members into six rate groups. Five rate groups align with managed care rate cells based on age, dual eligibility status, and managed care program. An additional rate group was assigned to members ineligible for managed care. Rate groups were selected due to having distinct cost profiles and trend considerations.

The State leveraged CY 2025 HealthChoice and DSNP capitation rate development for managed care eligible members. In addition, the State leveraged EDW claims and enrollment data received through January 5, 2026 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 2026 per member per month (PMPM) benefit expenses for non-waiver services reflected in the CY 2026 capitation rates for Other Waiver rate cells. The State 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; the State applied an acuity adjustment to each rate cell to reflect the acuity of the existing Persons with Disabilities 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) SFY 2025 PMPM non-waiver expenditures for Medicaid enrollees with an open Persons with Disabilities waiver segment.

To estimate Factor D', the State trended non-waiver PMPM base benefit expenses from the midpoint of the base experience period to the midpoint of each waiver year. Trend assumptions were selected based on observed trends in EDW experience between SFY 2022 and SFY 2025. Trends were developed and applied separately for each rate group and composited across rate groups using the July 2025 Persons with Disabilities waiver enrollment distribution. The State annualized PMPM costs for each waiver year using the projected average length of stay (ALOS). Year over year changes in values illustrated in Appendix J-1 vary due to differences in ALOS and mix changes resulting from trends being developed at the rate group level.

Factor G' is noted to be greater than Factor D'. This can be attributed to the observed historic experience within those populations. We've observed higher Prime costs for enrollees in a nursing facility than enrollees in a waiver, particularly for inpatient hospitalizations of the non-dual eligible population.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is the average annual per capita institutional cost for institutional recipients with a comparable level of care. The comparable population was identified using age criteria aligned with the targeted Persons with Disabilities waiver population. To estimate costs in the Factor G population, the state stratified members into six rate groups. Five rate groups align with managed care rate cells based on age, dual eligibility status, and managed care program. An additional rate group was assigned to members ineligible for managed care. Rate groups were selected due to having distinct cost profiles and trend considerations.

The State leveraged CY 2026 HealthChoice and DSNP capitation rate development for managed care eligible members. Additionally, the State leveraged EDW claims and enrollment data provided January 2026 for managed care ineligible members as well as services covered outside of managed care.

- For managed care eligible members, base benefits reflect CY 2026 PMPM benefit expenses for institutional services reflected in the CY 2026 capitation rates for Nursing Facility rate cells.
- For managed care ineligible members, base benefit expenses reflect FFS SFY 2025 PMPM institutional expenditures for Medicaid enrollees with a comparable level of care institutionalized in a nursing facility during that month.

To estimate Factor G, the State trended institutional PMPM base benefit expenses from the midpoint of the base experience period to the midpoint of each waiver year. Unit cost trend assumptions were developed based on observed trends in EDW experience between SFY 2022 and SFY 2025. The State composited PMPMs across rate cells and managed care ineligible members using the July 2025 Persons with Disabilities waiver enrollment distribution. The State annualized PMPM costs for each waiver year using the projected ALOS. Year over year changes in values illustrated in Appendix J-1 vary due to differences in ALOS and mix changes resulting from trends being developed at the rate group level.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is the average per capita state plan service cost for the same institutional recipients used in Factor G development. To estimate costs in the Factor G population, the State stratified members into six rate groups. Five rate groups align with managed care rate cells based on age, dual eligibility status, and managed care program. An additional rate group was assigned to members ineligible for managed care. Rate groups were selected due to having distinct cost profiles and trend considerations.

The State leveraged CY 2026 HealthChoice and DSNP capitation rate development for managed care eligible members. In addition, the State leveraged EDW claims and enrollment data provided January 2026 for managed care ineligible members as well as services covered outside of managed care.

- For managed care eligible members, base benefits reflect CY 2026 PMPM benefit expenses for non-institutional services reflected in the CY 2026 capitation rates for Nursing Facility rate cells.
- For managed care ineligible members, base benefit expenses reflect FFS SFY 2025 PMPM non-institutional expenditures for Medicaid enrollees with a comparable level of care institutionalized in a nursing facility.

To estimate Factor G', the State trended non-institutional PMPM base benefit expenses from the midpoint of the base experience period to the midpoint of each waiver year. Unit cost and utilization trend assumptions were developed based on observed trends in EDW experience between SFY 2022 and SFY 2025. The State composited PMPMs across rate cells and managed care ineligible members using the July 2025 Persons with Disabilities waiver enrollment distribution. The State annualized PMPM costs for each waiver year using the projected ALOS. Year-over-year changes in values illustrated in Appendix J-1 vary due to differences in ALOS and mix changes resulting from trends developed at the rate group level.

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	
Homemaker	
Individual Provider	
Respite	
Home Health Aide	
Occupational Therapy	
Physical Therapy	
Speech Therapy	
Environmental Accessibility Adaptations	
Home Delivered Meals	
In-Home Shift Nursing	
Intermittent Nursing	
Personal Emergency Response System	
Specialized Medical Equipment	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent 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:							**1608762.99**
Adult Day Service	☑	Hour	89	675.61	18.04	**1084732.39**	
Adult Day Service -FFS	☐	Hour	33	523.01	18.04	**311358.31**	
Adult Day Service Transportation	☑	Per Trip	73	170.20	13.33	**165619.92**	
Adult Day Transportation - FFS	☐	Per Trip	23	153.47	13.33	**47052.37**	
Homemaker Total:							**193268570.19**

GRAND TOTAL: **1268468384.70**

Total: Services included in capitation: 904048444.78

Total: Services not included in capitation: 364419939.93

Total Estimated Unduplicated Participants: **38886**

Factor D (Divide total by number of participants): **32620.18**

Services included in capitation: 23248.69

Services not included in capitation: 9371.49

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker	☑	Hour	5297	783.63	33.95	**140922651.33**	
Homemaker - FFS	☐	Hour	2104	732.82	33.95	**52345918.86**	
Individual Provider Total:							**1052057530.80**
Individual Provider	☑	Hour	22986	1481.60	21.92	**746508782.59**	
Individual Provider - FFS	☐	Hour	11663	1195.17	21.92	**305548748.20**	
Respite Total:							**107795.06**
Respite RN	☑	Hour	10	1.00	40.02	**400.20**	
Respite RN - FFS	☐	Hour	10	1.00	40.02	**400.20**	
Respite LPN	☑	Hour	10	1.00	32.86	**328.60**	
Respite LPN - FFS	☐	Hour	10	1.00	32.86	**328.60**	
Respite Homemaker	☑	Hour	10	101.85	33.95	**34578.08**	
Respite Homemaker - FFS	☐	Hour	10	195.87	33.95	**66497.86**	
Respite Individual Provider	☑	Hour	10	17.85	21.92	**3912.72**	
Respite Individual Provider - FFS	☐	Hour	10	1.00	21.92	**219.20**	
Respite Home Health Aide (CNA)	☑	Hour	10	1.00	25.11	**251.10**	
Respite Home Health Aide (CNA) - FFS	☐	Hour	10	1.00	25.11	**251.10**	
Respite Adult Day Service	☑	Hour	10	1.00	18.04	**180.40**	
Respite Adult Day Service - FFS	☐	Hour	10	1.00	18.04	**180.40**	
Respite Adult Day Service Transportation	☑	Per trip	10	1.00	13.33	**133.30**	
Respite Adult Day Service Transportation	☐	Per trip	10	1.00	13.33	**133.30**	

GRAND TOTAL: ***1268468384.70***

Total: Services included in capitation: *904048444.78*

Total: Services not included in capitation: *364419939.93*

Total Estimated Unduplicated Participants: ***38886***

Factor D (Divide total by number of participants): ***32620.18***

Services included in capitation: *23248.69*

Services not included in capitation: *9371.49*

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
- FFS							
Home Health Aide Total:							**2932343.73**
Home Health Aide Agency (CNA)	☑	Hour	10	1.00	27.83	**278.30**	
Home Health Aide Agency (CNA) - FFS	☐	Hour	10	1293.76	27.83	**360053.41**	
Home Health Aide Independent (CNA)	☑	Hour	61	1096.21	25.11	**1679075.82**	
Home Health Aide Independent (CNA) - FFS	☐	Hour	42	846.69	25.11	**892936.21**	
Occupational Therapy Total:							**2220.00**
Occupational Therapist	☑	Hour	10	1.00	111.00	**1110.00**	
Occupational Therapist - FFS	☐	Hour	10	1.00	111.00	**1110.00**	
Physical Therapy Total:							**2220.00**
Physical Therapist	☑	Hour	10	1.00	111.00	**1110.00**	
Physical Therapist - FFS	☐	Hour	10	1.00	111.00	**1110.00**	
Speech Therapy Total:							**2220.00**
Speech Therapy	☑	Hour	10	1.00	111.00	**1110.00**	
Speech Therapy - FFS	☐	Hour	10	1.00	111.00	**1110.00**	
Environmental Accessibility Adaptations Total:							**5323415.17**
Environmental Accessibility Adaptations	☑	Per item	260	1.34	10237.14	**3566619.58**	
Environmental Accessibility Adaptations - FFS	☐	Per item	131	1.31	10237.14	**1756795.60**	
Home Delivered Meals Total:							**8142661.76**
Home Delivered	☑	Day	2161	177.90	17.05	**6554734.40**	

GRAND TOTAL: **1268468384.70**

Total: Services included in capitation: 904048444.78

Total: Services not included in capitation: 364419939.93

Total Estimated Unduplicated Participants: **38886**

Factor D (Divide total by number of participants): **32620.18**

Services included in capitation: 23248.69

Services not included in capitation: 9371.49

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals							
Home Delivered Meals - FFS	☐	Day	577	161.41	17.05	1587927.37	
In-Home Shift Nursing Total:							2297081.46
In-Home Shift Nursing RN Agency	☑	Hour	10	1.00	48.21	482.10	
In-Home Shift Nursing RN Agency - FFS	☐	Hour	10	44.01	48.21	21217.22	
In-Home Shift Nursing LPN Agency	☑	Hour	10	1.00	40.95	409.50	
In-Home Shift Nursing LPN Agency - FFS	☐	Hour	10	1.00	40.95	409.50	
In-Home Shift Nursing Multi Customer Nurse	☑	Hour	10	1.00	50.65	506.50	
In-Home Shift Nursing Multi Customer Nurse - FFS	☐	Hour	10	1.00	50.65	506.50	
In-Home Shift Nursing RN Independent	☑	Hour	10	684.54	40.02	273952.91	
In-Home Shift Nursing RN Independent - FFS	☐	Hour	13	1292.38	40.02	672373.62	
In-Home Shift Nursing LPN Independent	☑	Hour	19	1560.55	32.86	974313.79	
In-Home Shift Nursing LPN Independent - FFS	☐	Hour	10	1073.98	32.86	352909.83	
Intermittent Nursing Total:							29335.10
Intermittent Nursing	☑	Hour	10	1.00	118.91	1189.10	
Intermittent Nursing - FFS	☐	Hour	10	23.67	118.91	28146.00	
Personal Emergency Response System Total:							2598004.57
Personal Emergency Response (Monthly	☑	Monthly	7159	10.25	29.60	2172040.60	

GRAND TOTAL: 1268468384.70

Total: Services included in capitation: 904048444.78

Total: Services not included in capitation: 364419939.93

Total Estimated Unduplicated Participants: 38886

Factor D (Divide total by number of participants): 32620.18

Services included in capitation: 23248.69

Services not included in capitation: 9371.49

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Monitoring)							
Personal Emergency Response (Monthly Monitoring) - FFS	☐	Monthly	1569	7.48	29.60	347389.15	
Personal Emergency Response (Install)	☑	One time	1614	1.00	42.29	68256.06	
Personal Emergency Response (Install) - FFS	☐	One time	244	1.00	42.29	10318.76	
Specialized Medical Equipment Total:							96223.87
Specialized Medical Equipment	☑	Per item	10	1.14	2779.43	31685.50	
Specialized Medical Equipment - FFS	☐	Per item	18	1.29	2779.43	64538.36	

GRAND TOTAL: 1268468384.70
Total: Services included in capitation: 904048444.78
Total: Services not included in capitation: 364419939.93
Total Estimated Unduplicated Participants: 38886
Factor D (Divide total by number of participants): 32620.18
Services included in capitation: 23248.69
Services not included in capitation: 9371.49
Average Length of Stay on the Waiver: 313

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							1852086.28

GRAND TOTAL: 1485779234.91
Total: Services included in capitation: 1058964436.14
Total: Services not included in capitation: 426814798.77
Total Estimated Unduplicated Participants: 41283
Factor D (Divide total by number of participants): 35990.10
Services included in capitation: 25651.34
Services not included in capitation: 10338.75
Average Length of Stay on the Waiver: 314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Adult Day Service	☑	Hour	94	711.38	18.67	**1248457.67**	
Adult Day Service -FFS	☐	Hour	35	550.70	18.67	**359854.92**	
Adult Day Service Transportation	☑	Per Trip	77	179.21	13.79	**190290.55**	
Adult Day Transportation - FFS	☐	Per Trip	24	161.60	13.79	**53483.14**	
Homemaker Total:							**230132146.39**
Homemaker	☑	Hour	5624	825.12	36.16	**167799571.66**	
Homemaker - FFS	☐	Hour	2234	771.62	36.16	**62332574.73**	
Individual Provider Total:							**1228915599.17**
Individual Provider	☑	Hour	24403	1530.34	23.35	**872003111.92**	
Individual Provider - FFS	☐	Hour	12382	1234.48	23.35	**356912487.26**	
Respite Total:							**132757.49**
Respite RN	☑	Hour	11	1.03	41.42	**469.29**	
Respite RN - FFS	☐	Hour	11	1.03	41.42	**469.29**	
Respite LPN	☑	Hour	11	1.03	34.34	**389.07**	
Respite LPN - FFS	☐	Hour	11	1.03	34.34	**389.07**	
Respite Homemaker	☑	Hour	11	107.24	36.16	**42655.78**	
Respite Homemaker - FFS	☐	Hour	11	206.24	36.16	**82034.02**	
Respite Individual Provider	☑	Hour	11	18.44	23.35	**4736.31**	
Respite Individual Provider - FFS	☐	Hour	11	1.03	23.35	**264.56**	
Respite Home Health Aide (CNA)	☑	Hour	11	1.03	26.49	**300.13**	

GRAND TOTAL: ***1485779234.91***

Total: Services included in capitation: *1058964436.14*

Total: Services not included in capitation: *426814798.77*

Total Estimated Unduplicated Participants: ***41283***

Factor D (Divide total by number of participants): ***35990.10***

Services included in capitation: *25651.34*

Services not included in capitation: *10338.75*

Average Length of Stay on the Waiver: 314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Home Health Aide (CNA) - FFS	☐	Hour	11	1.03	26.49	300.13	
Respite Adult Day Service	☑	Hour	11	1.05	18.67	215.64	
Respite Adult Day Service - FFS	☐	Hour	11	1.05	18.67	215.64	
Respite Adult Day Service Transportation	☑	Per trip	11	1.05	13.79	159.27	
Respite Adult Day Service Transportation - FFS	☐	Per trip	11	1.05	13.79	159.27	
Home Health Aide Total:							3424005.06
Home Health Aide Agency (CNA)	☑	Hour	11	1.03	29.36	332.65	
Home Health Aide Agency (CNA) - FFS	☐	Hour	11	1336.32	29.36	431577.91	
Home Health Aide Independent (CNA)	☑	Hour	65	1132.27	26.49	1949599.10	
Home Health Aide Independent (CNA) - FFS	☐	Hour	45	874.54	26.49	1042495.41	
Occupational Therapy Total:							2515.26
Occupational Therapist	☑	Hour	11	1.03	111.00	1257.63	
Occupational Therapist - FFS	☐	Hour	11	1.03	111.00	1257.63	
Physical Therapy Total:							2515.26
Physical Therapist	☑	Hour	11	1.03	111.00	1257.63	
Physical Therapist - FFS	☐	Hour	11	1.03	111.00	1257.63	
Speech Therapy Total:							2515.26
Speech Therapy	☑	Hour	11	1.03	111.00	1257.63	
Speech Therapy - FFS	☐	Hour	11	1.03	111.00	1257.63	
Environmental							6115163.09

GRAND TOTAL: 1485779234.91

Total: Services included in capitation: 1058964436.14

Total: Services not included in capitation: 426814798.77

Total Estimated Unduplicated Participants: 41283

Factor D (Divide total by number of participants): 35990.10

Services included in capitation: 25651.34

Services not included in capitation: 10338.75

Average Length of Stay on the Waiver: 314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility Adaptations Total:							
Environmental Accessibility Adaptations	☑	Per item	276	1.41	10525.60	**4096142.50**	
Environmental Accessibility Adaptations - FFS	☐	Per item	139	1.38	10525.60	**2019020.59**	
Home Delivered Meals Total:							**9423291.93**
Home Delivered Meals	☑	Day	2294	187.32	17.65	**7584418.21**	
Home Delivered Meals - FFS	☐	Day	613	169.96	17.65	**1838873.72**	
In-Home Shift Nursing Total:							**2649967.34**
In-Home Shift Nursing RN Agency	☑	Hour	11	1.03	49.89	**565.25**	
In-Home Shift Nursing RN Agency - FFS	☐	Hour	11	45.46	49.89	**24947.99**	
In-Home Shift Nursing LPN Agency	☑	Hour	11	1.03	42.79	**484.81**	
In-Home Shift Nursing LPN Agency - FFS	☐	Hour	11	1.03	42.79	**484.81**	
In-Home Shift Nursing Multi Customer Nurse	☑	Hour	11	1.03	52.42	**593.92**	
In-Home Shift Nursing Multi Customer Nurse - FFS	☐	Hour	11	1.03	52.42	**593.92**	
In-Home Shift Nursing RN Independent	☑	Hour	11	707.06	41.42	**322150.68**	
In-Home Shift Nursing RN Independent - FFS	☐	Hour	14	1334.89	41.42	**774076.01**	
In-Home Shift Nursing LPN Independent	☑	Hour	20	1611.88	34.34	**1107039.18**	
In-Home Shift Nursing LPN Independent - FFS	☐	Hour	11	1109.31	34.34	**419030.76**	
Intermittent							**34494.06**

GRAND TOTAL: **1485779234.91**

Total: Services included in capitation: 1058964436.14

Total: Services not included in capitation: 426814798.77

Total Estimated Unduplicated Participants: **41283**

Factor D (Divide total by number of participants): **35990.10**

Services included in capitation: 25651.34

Services not included in capitation: 10338.75

Average Length of Stay on the Waiver: 314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:							
Intermittent Nursing	☑	Hour	11	1.03	123.07	**1394.38**	
Intermittent Nursing - FFS	☐	Hour	11	24.45	123.07	**33099.68**	
Personal Emergency Response System Total:							**2980611.75**
Personal Emergency Response (Monthly Monitoring)	☑	Monthly	7600	10.79	30.43	**2495381.72**	
Personal Emergency Response (Monthly Monitoring) - FFS	☐	Monthly	1666	7.88	30.43	**399487.47**	
Personal Emergency Response (Install)	☑	One time	1713	1.00	43.48	**74481.24**	
Personal Emergency Response (Install) - FFS	☐	One time	259	1.00	43.48	**11261.32**	
Specialized Medical Equipment Total:							**111566.56**
Specialized Medical Equipment	☑	Per item	11	1.20	2857.75	**37722.30**	
Specialized Medical Equipment - FFS	☐	Per item	19	1.36	2857.75	**73844.26**	

GRAND TOTAL: **1485779234.91**

Total: Services included in capitation: 1058964436.14

Total: Services not included in capitation: 426814798.77

Total Estimated Unduplicated Participants: **41283**

Factor D (Divide total by number of participants): **35990.10**

Services included in capitation: 25651.34

Services not included in capitation: 10338.75

Average Length of Stay on the Waiver: 314

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:							**2131387.47**
Adult Day Service	☑	Hour	100	744.86	19.32	**1439069.52**	
Adult Day Service -FFS	☐	Hour	37	576.62	19.32	**412191.04**	
Adult Day Service Transportation	☑	Per Trip	82	187.64	14.28	**219718.93**	
Adult Day Transportation - FFS	☐	Per Trip	25	169.21	14.28	**60407.97**	
Homemaker Total:							**272461297.30**
Homemaker	☑	Hour	5971	863.95	38.51	**198659436.28**	
Homemaker - FFS	☐	Hour	2372	807.94	38.51	**73801861.02**	
Individual Provider Total:							**1427373975.39**
Individual Provider	☑	Hour	25909	1571.84	24.87	**1012825839.67**	
Individual Provider - FFS	☐	Hour	13146	1267.96	24.87	**414548135.72**	
Respite Total:							**161256.81**
Respite RN	☑	Hour	12	1.06	42.87	**545.31**	
Respite RN - FFS	☐	Hour	12	1.06	42.87	**545.31**	
Respite LPN	☑	Hour	12	1.06	35.89	**456.52**	
Respite LPN - FFS	☐	Hour	12	1.06	35.89	**456.52**	
Respite Homemaker	☑	Hour	12	112.29	38.51	**51891.45**	
Respite Homemaker - FFS	☐	Hour	12	215.95	38.51	**99794.81**	
Respite Individual Provider	☑	Hour	12	18.94	24.87	**5652.45**	
Respite Individual Provider - FFS	☐	Hour	12	1.06	24.87	**316.35**	
Respite Home Health Aide (CNA)	☑	Hour	12	1.06	27.95	**355.52**	

GRAND TOTAL: **1730531289.09**

Total: Services included in capitation: 1233472100.56

Total: Services not included in capitation: 497059188.53

Total Estimated Unduplicated Participants: **43830**

Factor D (Divide total by number of participants): **39482.80**

Services included in capitation: 28142.19

Services not included in capitation: 11340.62

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Home Health Aide (CNA) - FFS	☐	Hour	12	1.06	27.95	355.52	
Respite Adult Day Service	☑	Hour	12	1.10	19.32	255.02	
Respite Adult Day Service - FFS	☐	Hour	12	1.10	19.32	255.02	
Respite Adult Day Service Transportation	☑	Per trip	12	1.10	14.28	188.50	
Respite Adult Day Service Transportation - FFS	☐	Per trip	12	1.10	14.28	188.50	
Home Health Aide Total:							3958462.83
Home Health Aide Agency (CNA)	☑	Hour	12	1.06	30.97	393.94	
Home Health Aide Agency (CNA) - FFS	☐	Hour	12	1372.56	30.97	510098.20	
Home Health Aide Independent (CNA)	☑	Hour	69	1162.98	27.95	2242865.08	
Home Health Aide Independent (CNA) - FFS	☐	Hour	48	898.26	27.95	1205105.62	
Occupational Therapy Total:							2823.84
Occupational Therapist	☑	Hour	12	1.06	111.00	1411.92	
Occupational Therapist - FFS	☐	Hour	12	1.06	111.00	1411.92	
Physical Therapy Total:							2823.84
Physical Therapist	☑	Hour	12	1.06	111.00	1411.92	
Physical Therapist - FFS	☐	Hour	12	1.06	111.00	1411.92	
Speech Therapy Total:							2823.84
Speech Therapy	☑	Hour	12	1.06	111.00	1411.92	
Speech Therapy - FFS	☐	Hour	12	1.06	111.00	1411.92	
Environmental							6999359.60

GRAND TOTAL: 1730531289.09

Total: Services included in capitation: 1233472100.56

Total: Services not included in capitation: 497059188.53

Total Estimated Unduplicated Participants: 43830

Factor D (Divide total by number of participants): 39482.80

Services included in capitation: 28142.19

Services not included in capitation: 11340.62

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility Adaptations Total:							
Environmental Accessibility Adaptations	☑	Per item	293	1.48	10822.19	**4692934.47**	
Environmental Accessibility Adaptations - FFS	☐	Per item	148	1.44	10822.19	**2306425.13**	
Home Delivered Meals Total:							**10840030.74**
Home Delivered Meals	☑	Day	2436	196.14	18.26	**8724573.95**	
Home Delivered Meals - FFS	☐	Day	651	177.96	18.26	**2115456.79**	
In-Home Shift Nursing Total:							**3025902.81**
In-Home Shift Nursing RN Agency	☑	Hour	12	1.06	51.64	**656.86**	
In-Home Shift Nursing RN Agency - FFS	☐	Hour	12	46.69	51.64	**28932.86**	
In-Home Shift Nursing LPN Agency	☑	Hour	12	1.06	44.72	**568.84**	
In-Home Shift Nursing LPN Agency - FFS	☐	Hour	12	1.06	44.72	**568.84**	
In-Home Shift Nursing Multi Customer Nurse	☑	Hour	12	1.06	54.25	**690.06**	
In-Home Shift Nursing Multi Customer Nurse - FFS	☐	Hour	12	1.06	54.25	**690.06**	
In-Home Shift Nursing RN Independent	☑	Hour	12	726.23	42.87	**373601.76**	
In-Home Shift Nursing RN Independent - FFS	☐	Hour	15	1371.09	42.87	**881679.42**	
In-Home Shift Nursing LPN Independent	☑	Hour	21	1655.59	35.89	**1247801.63**	
In-Home Shift Nursing LPN Independent - FFS	☐	Hour	12	1139.39	35.89	**490712.49**	
Intermittent							**40002.42**

GRAND TOTAL: **1730531289.09**

Total: Services included in capitation: 1233472100.56

Total: Services not included in capitation: 497059188.53

Total Estimated Unduplicated Participants: **43830**

Factor D (Divide total by number of participants): **39482.80**

Services included in capitation: 28142.19

Services not included in capitation: 11340.62

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:							
Intermittent Nursing	☑	Hour	12	1.06	127.38	**1620.27**	
Intermittent Nursing - FFS	☐	Hour	12	25.11	127.38	**38382.14**	
Personal Emergency Response System Total:							**3403268.70**
Personal Emergency Response (Monthly Monitoring)	☑	Monthly	8069	11.30	31.29	**2853012.81**	
Personal Emergency Response (Monthly Monitoring) - FFS	☐	Monthly	1769	8.25	31.29	**456654.08**	
Personal Emergency Response (Install)	☑	One time	1819	1.00	44.70	**81309.30**	
Personal Emergency Response (Install) - FFS	☐	One time	275	1.00	44.70	**12292.50**	
Specialized Medical Equipment Total:							**127873.51**
Specialized Medical Equipment	☑	Per item	12	1.26	2938.27	**44426.64**	
Specialized Medical Equipment - FFS	☐	Per item	20	1.42	2938.27	**83446.87**	

GRAND TOTAL: **1730531289.09**

Total: Services included in capitation: 1233472100.56

Total: Services not included in capitation: 497059188.53

Total Estimated Unduplicated Participants: **43830**

Factor D (Divide total by number of participants): **39482.80**

Services included in capitation: 28142.19

Services not included in capitation: 11340.62

Average Length of Stay on the Waiver: 313

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:							**2454295.75**
Adult Day Service	☑	Hour	106	782.09	20.00	**1658030.80**	
Adult Day Service -FFS	☐	Hour	39	605.44	20.00	**472243.20**	
Adult Day Service Transportation	☑	Per Trip	87	197.02	14.77	**253168.73**	
Adult Day Transportation - FFS	☐	Per Trip	27	177.67	14.77	**70853.02**	
Homemaker Total:							**323419903.70**
Homemaker	☑	Hour	6339	907.13	41.01	**235819682.84**	
Homemaker - FFS	☐	Hour	2518	848.32	41.01	**87600220.86**	
Individual Provider Total:							**1661888931.14**
Individual Provider	☑	Hour	27507	1618.96	26.48	**1179226762.43**	
Individual Provider - FFS	☐	Hour	13957	1305.97	26.48	**482662168.72**	
Respite Total:							**195024.55**
Respite RN	☑	Hour	13	1.09	44.37	**628.72**	
Respite RN - FFS	☐	Hour	13	1.09	44.37	**628.72**	
Respite LPN	☑	Hour	13	1.09	37.50	**531.38**	
Respite LPN - FFS	☐	Hour	13	1.09	37.50	**531.38**	
Respite Homemaker	☑	Hour	13	117.90	41.01	**62856.03**	
Respite Homemaker - FFS	☐	Hour	13	226.74	41.01	**120881.90**	
Respite Individual Provider	☑	Hour	13	19.51	26.48	**6716.12**	
Respite Individual Provider - FFS	☐	Hour	13	1.09	26.48	**375.22**	
Respite Home Health Aide (CNA)	☑	Hour	13	1.09	29.48	**417.73**	

GRAND TOTAL: **2020581243.91**

Total: Services included in capitation: 1440293117.76

Total: Services not included in capitation: 580288126.15

Total Estimated Unduplicated Participants: **46534**

Factor D (Divide total by number of participants): **43421.61**

Services included in capitation: 30951.41

Services not included in capitation: 12470.20

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Home Health Aide (CNA) - FFS	☐	Hour	13	1.09	29.48	417.73	
Respite Adult Day Service	☑	Hour	13	1.15	20.00	299.00	
Respite Adult Day Service - FFS	☐	Hour	13	1.15	20.00	299.00	
Respite Adult Day Service Transportation	☑	Per trip	13	1.15	14.77	220.81	
Respite Adult Day Service Transportation - FFS	☐	Per trip	13	1.15	14.77	220.81	
Home Health Aide Total:							4569705.48
Home Health Aide Agency (CNA)	☑	Hour	13	1.09	32.67	462.93	
Home Health Aide Agency (CNA) - FFS	☐	Hour	13	1413.71	32.67	600416.77	
Home Health Aide Independent (CNA)	☑	Hour	73	1197.85	29.48	2577821.11	
Home Health Aide Independent (CNA) - FFS	☐	Hour	51	925.19	29.48	1391004.66	
Occupational Therapy Total:							3145.74
Occupational Therapist	☑	Hour	13	1.09	111.00	1572.87	
Occupational Therapist - FFS	☐	Hour	13	1.09	111.00	1572.87	
Physical Therapy Total:							3145.74
Physical Therapist	☑	Hour	13	1.09	111.00	1572.87	
Physical Therapist - FFS	☐	Hour	13	1.09	111.00	1572.87	
Speech Therapy Total:							3145.74
Speech Therapy	☑	Hour	13	1.09	111.00	1572.87	
Speech Therapy - FFS	☐	Hour	13	1.09	111.00	1572.87	
Environmental							8001748.92

GRAND TOTAL: 2020581243.91

Total: Services included in capitation: 1440293117.76

Total: Services not included in capitation: 580288126.15

Total Estimated Unduplicated Participants: 46534

Factor D (Divide total by number of participants): 43421.61

Services included in capitation: 30951.41

Services not included in capitation: 12470.20

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility Adaptations Total:							
Environmental Accessibility Adaptations	☑	Per item	311	1.55	11127.14	**5363837.84**	
Environmental Accessibility Adaptations - FFS	☐	Per item	157	1.51	11127.14	**2637911.08**	
Home Delivered Meals Total:							**12505642.19**
Home Delivered Meals	☑	Day	2586	205.94	18.90	**10065399.88**	
Home Delivered Meals - FFS	☐	Day	691	186.85	18.90	**2440242.32**	
In-Home Shift Nursing Total:							**3450011.62**
In-Home Shift Nursing RN Agency	☑	Hour	13	1.09	53.45	**757.39**	
In-Home Shift Nursing RN Agency - FFS	☐	Hour	13	48.09	53.45	**33415.34**	
In-Home Shift Nursing LPN Agency	☑	Hour	13	1.09	46.73	**662.16**	
In-Home Shift Nursing LPN Agency - FFS	☐	Hour	13	1.09	46.73	**662.16**	
In-Home Shift Nursing Multi Customer Nurse	☑	Hour	13	1.09	56.15	**795.65**	
In-Home Shift Nursing Multi Customer Nurse - FFS	☐	Hour	13	1.09	56.15	**795.65**	
In-Home Shift Nursing RN Independent	☑	Hour	13	748.00	44.37	**431453.88**	
In-Home Shift Nursing RN Independent - FFS	☐	Hour	16	1412.20	44.37	**1002549.02**	
In-Home Shift Nursing LPN Independent	☑	Hour	22	1705.23	37.50	**1406814.75**	
In-Home Shift Nursing LPN Independent - FFS	☐	Hour	13	1173.55	37.50	**572105.62**	
Intermittent							**46186.64**

GRAND TOTAL: **2020581243.91**

Total: Services included in capitation: 1440293117.76

Total: Services not included in capitation: 580288126.15

Total Estimated Unduplicated Participants: **46534**

Factor D (Divide total by number of participants): **43421.61**

Services included in capitation: 30951.41

Services not included in capitation: 12470.20

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:							
Intermittent Nursing	☑	Hour	13	1.09	131.83	**1868.03**	
Intermittent Nursing - FFS	☐	Hour	13	25.86	131.83	**44318.61**	
Personal Emergency Response System Total:							**3893985.86**
Personal Emergency Response (Monthly Monitoring)	☑	Monthly	8567	11.86	32.17	**3268620.63**	
Personal Emergency Response (Monthly Monitoring) - FFS	☐	Monthly	1878	8.66	32.17	**523196.15**	
Personal Emergency Response (Install)	☑	One time	1931	1.00	45.96	**88748.76**	
Personal Emergency Response (Install) - FFS	☐	One time	292	1.00	45.96	**13420.32**	
Specialized Medical Equipment Total:							**146370.84**
Specialized Medical Equipment	☑	Per item	13	1.32	3021.07	**51841.56**	
Specialized Medical Equipment - FFS	☐	Per item	21	1.49	3021.07	**94529.28**	

GRAND TOTAL: **2020581243.91**

Total: Services included in capitation: 1440293117.76

Total: Services not included in capitation: 580288126.15

Total Estimated Unduplicated Participants: **46534**

Factor D (Divide total by number of participants): **43421.61**

Services included in capitation: 30951.41

Services not included in capitation: 12470.20

Average Length of Stay on the Waiver: 313

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:							**2834172.89**
Adult Day Service	☑	Hour	113	821.21	20.70	**1920892.31**	
Adult Day Service -FFS	☐	Hour	41	635.73	20.70	**539544.05**	
Adult Day Service Transportation	☑	Per Trip	92	206.88	15.29	**291013.96**	
Adult Day Transportation - FFS	☐	Per Trip	29	186.56	15.29	**82722.57**	
Homemaker Total:							**384006912.74**
Homemaker	☑	Hour	6730	952.51	43.68	**280005935.66**	
Homemaker - FFS	☐	Hour	2673	890.75	43.68	**104000977.08**	
Individual Provider Total:							**1935430845.34**
Individual Provider	☑	Hour	29204	1667.56	28.20	**1373323707.17**	
Individual Provider - FFS	☐	Hour	14818	1345.18	28.20	**562107138.17**	
Respite Total:							**234538.51**
Respite RN	☑	Hour	14	1.12	45.93	**720.18**	
Respite RN - FFS	☐	Hour	14	1.12	45.93	**720.18**	
Respite LPN	☑	Hour	14	1.12	39.19	**614.50**	
Respite LPN - FFS	☐	Hour	14	1.12	39.19	**614.50**	
Respite Homemaker	☑	Hour	14	123.80	43.68	**75706.18**	
Respite Homemaker - FFS	☐	Hour	14	238.08	43.68	**145590.68**	
Respite Individual Provider	☑	Hour	14	20.10	28.20	**7935.48**	
Respite Individual Provider - FFS	☐	Hour	14	1.12	28.20	**442.18**	
Respite Home Health Aide (CNA)	☑	Hour	14	1.12	31.10	**487.65**	

GRAND TOTAL: **2360029700.81**

Total: Services included in capitation: 1682377062.52

Total: Services not included in capitation: 677652638.28

Total Estimated Unduplicated Participants: **49404**

Factor D (Divide total by number of participants): **47770.01**

Services included in capitation: 34053.46

Services not included in capitation: 13716.55

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Home Health Aide (CNA) - FFS	☐	Hour	14	1.12	31.10	487.65	
Respite Adult Day Service	☑	Hour	14	1.21	20.70	350.66	
Respite Adult Day Service - FFS	☐	Hour	14	1.21	20.70	350.66	
Respite Adult Day Service Transportation	☑	Trip	14	1.21	15.29	259.01	
Respite Adult Day Service Transportation - FFS	☐	Trip	14	1.21	15.29	259.01	
Home Health Aide Total:							5296643.47
Home Health Aide Agency (CNA)	☑	Hour	14	1.12	34.47	540.49	
Home Health Aide Agency (CNA) - FFS	☐	Hour	14	1456.15	34.47	702708.87	
Home Health Aide Independent (CNA)	☑	Hour	78	1233.81	31.10	2992976.30	
Home Health Aide Independent (CNA) - FFS	☐	Hour	54	952.97	31.10	1600417.82	
Occupational Therapy Total:							3480.96
Occupational Therapist	☑	Hour	14	1.12	111.00	1740.48	
Occupational Therapist - FFS	☐	Hour	14	1.12	111.00	1740.48	
Physical Therapy Total:							3480.96
Physical Therapist	☑	Hour	14	1.12	111.00	1740.48	
Physical Therapist - FFS	☐	Hour	14	1.12	111.00	1740.48	
Speech Therapy Total:							3480.96
Speech Therapy	☑	Hour	14	1.12	111.00	1740.48	
Speech Therapy - FFS	☐	Hour	14	1.12	111.00	1740.48	
Environmental							9191785.53

GRAND TOTAL: 2360029700.81

Total: Services included in capitation: 1682377062.52

Total: Services not included in capitation: 677652638.28

Total Estimated Unduplicated Participants: 49404

Factor D (Divide total by number of participants): 47770.01

Services included in capitation: 34053.46

Services not included in capitation: 13716.55

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility Adaptations Total:							
Environmental Accessibility Adaptations	☑	Per item	330	1.63	11440.68	**6153941.77**	
Environmental Accessibility Adaptations - FFS	☐	Per item	167	1.59	11440.68	**3037843.76**	
Home Delivered Meals Total:							**14427252.58**
Home Delivered Meals	☑	Day	2745	216.24	19.56	**11610401.33**	
Home Delivered Meals - FFS	☐	Day	734	196.20	19.56	**2816851.25**	
In-Home Shift Nursing Total:							**3920162.31**
In-Home Shift Nursing RN Agency	☑	Hour	14	1.12	55.32	**867.42**	
In-Home Shift Nursing RN Agency - FFS	☐	Hour	14	49.53	55.32	**38359.99**	
In-Home Shift Nursing LPN Agency	☑	Hour	14	1.12	48.83	**765.65**	
In-Home Shift Nursing LPN Agency - FFS	☐	Hour	14	1.12	48.83	**765.65**	
In-Home Shift Nursing Multi Customer Nurse	☑	Hour	14	1.12	58.12	**911.32**	
In-Home Shift Nursing Multi Customer Nurse - FFS	☐	Hour	14	1.12	58.12	**911.32**	
In-Home Shift Nursing RN Independent	☑	Hour	14	770.46	45.93	**495421.19**	
In-Home Shift Nursing RN Independent - FFS	☐	Hour	17	1454.60	45.93	**1135766.23**	
In-Home Shift Nursing LPN Independent	☑	Hour	23	1756.42	39.19	**1583184.30**	
In-Home Shift Nursing LPN Independent - FFS	☐	Hour	14	1208.78	39.19	**663209.23**	
Intermittent							**53029.93**

GRAND TOTAL: **2360029700.81**

Total: Services included in capitation: 1682377062.52

Total: Services not included in capitation: 677652638.28

Total Estimated Unduplicated Participants: **49404**

Factor D (Divide total by number of participants): **47770.01**

Services included in capitation: 34053.46

Services not included in capitation: 13716.55

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:							
Intermittent Nursing	☑	Hour	14	1.12	136.45	**2139.54**	
Intermittent Nursing - FFS	☐	Hour	14	26.64	136.45	**50890.39**	
Personal Emergency Response System Total:							**4456863.19**
Personal Emergency Response (Monthly Monitoring)	☑	Monthly	9095	12.45	33.08	**3745739.37**	
Personal Emergency Response (Monthly Monitoring) - FFS	☐	Monthly	1994	9.09	33.08	**599590.22**	
Personal Emergency Response (Install)	☑	One time	2050	1.00	47.26	**96883.00**	
Personal Emergency Response (Install) - FFS	☐	One time	310	1.00	47.26	**14650.60**	
Specialized Medical Equipment Total:							**167051.44**
Specialized Medical Equipment	☑	Per item	14	1.39	3106.20	**60446.65**	
Specialized Medical Equipment - FFS	☐	Per item	22	1.56	3106.20	**106604.78**	

GRAND TOTAL: **2360029700.81**

Total: Services included in capitation: 1682377062.52

Total: Services not included in capitation: 677652638.28

Total Estimated Unduplicated Participants: **49404**

Factor D (Divide total by number of participants): **47770.01**

Services included in capitation: 34053.46

Services not included in capitation: 13716.55

Average Length of Stay on the Waiver: 313