

1915(i) State plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. **Services.** (Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):

- Family caregiver home health aide services

2. **Concurrent Operation with Other Programs.** (Indicate whether this benefit will operate concurrently with another Medicaid authority):

Select one:

<input checked="" type="radio"/>	Not applicable		
<input type="radio"/>	Applicable		
Check the applicable authority or authorities:			
<input type="checkbox"/>	Services furnished under the provisions of §1915(a)(1)(a) of the Act. 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 §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Customers may <i>voluntarily</i> 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. <i>Specify:</i> (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the specific 1915(i) State plan HCBS furnished by these plans; (d) how payments are made to the health plans; and (e) whether the 1915(a) contract has been submitted or previously approved.		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):			
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program operated under §1932(a) of the Act.		

		Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
<input type="checkbox"/>		A program authorized under §1115 of the Act. Specify the program:

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. (Select one):

<input type="radio"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (<i>select one</i>):	
<input type="radio"/>	The Medical Assistance Unit (<i>name of unit</i>):	Division of Medical Programs
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit (<i>name of division/unit</i>) <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	
<input checked="" type="radio"/>	The State plan HCBS benefit is operated by (<i>name of agency</i>) University of Illinois Chicago, Division of Specialized Care for Children a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State plan HCBS Operational and Administrative Functions.

- ☒ (By checking this box the state assures that): When the Medicaid agency does not directly conduct an administrative 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. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
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1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Review of customer service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The Illinois Department of Healthcare and Family Services (HFS), as Illinois' single state Medicaid Agency (MA), retains full authority and responsibility for the operation of the 1915(i) Home and Community-Based Service (HCBS) state plan amendment through direct administration and oversight of the operating agency (OA), the University of Illinois Chicago, Division of Specialized Care for Children (UIC/DSCC), and enrolled service providers.

In response to Public Act 103-0593, HFS is implementing this 1915(i) HCBS state plan amendment to reimburse legally responsible family caregivers as a Certified Nursing Assistant or Certified Nurse Aide (CNA) to provide personal care or home health aide services to a medically fragile relative who is under the age of 21 and receiving in-home shift nursing services coordinated by UIC/DSCC.

Delegation of Functions:

All functions not performed directly by the MA shall be delegated in writing to the OA. The MA shall directly supervise the operations and performance of the OA, including the review and approval of effective policies and procedures. No delegated entity performing any of the 1915(i) benefit operations may substitute its own judgment for that of the MA with respect to the application of rules, regulation, policies, or procedures.

Function 3 - Review of customer service plans.

The OA develops and reviews customer person-centered service plans. The MA provides oversight and monitoring through regular reporting by the OA.

Function 5 - Utilization management.

Utilization management of 1915(i) HCBS state plan services is a function of the OA. The OA reports utilization to MA on a quarterly basis.

Function 6 – Qualified provider enrollment.

Any willing and qualified provider may request to be enrolled in the Medicaid program. Providers may contact the OA through any of their statewide regional offices or go through the OA website to request information about the requirements and procedures to qualify. The OA verifies provider qualifications and coordinates with the MA on Medicaid enrollment.

Function 9 - Rules, policies, procedures, and information development governing the State plan HCBS benefit.

The MA shall be responsible for establishing state administrative rules governing the delivery of the 1915(i) HCBS state plan benefit for CNA services by the legally responsible family caregivers. Additionally, the MA shall establish applicable policies and procedures for the consistent delivery of the 1915(i) HCBS state plan benefit for CNA services by the legally responsible family caregiver. The MA shall review and approve all policies established by the OA to ensure compliance and adherence to the MA standards for the delivery of the 1915(i) HCBS state plan benefit for CNA services by the legally responsible family caregiver.

Function 10 - Quality assurance and quality improvement activities.

The OA conducts ongoing quality assurance reviews to monitor customer welfare, service access, and quality. The OA provides the MA with quality assurance reports of their monitoring activities, which includes a summary of noncompliance related to specific performance measures, overall summary of record review findings, and recommendations for remediation of non-compliance.

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

(By checking the following boxes the State assures that):

5. ☒ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
 - financially responsible for the individual
 - empowered to make financial or health-related decisions on behalf of the individual
 - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; 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. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*
6. ☒ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. ☒ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8. ☒ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Customers
Year 1	01/01/25	12/31/25	40
Year 2			
Year 3			
Year 4			
Year 5			

- 2. ☒ Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

- 1. ☒ Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

- 2. ☒ Medically Needy** *(Select one):*

The State does not provide State plan HCBS to the medically needy.

☒ The State provides State plan HCBS to the medically needy. *(Select one):*

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☒ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

- 1. Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent

evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

<input checked="checked" type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By Other (<i>specify State agency or entity under contract with the State Medicaid agency</i>):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. (*Specify qualifications*):

The MA is responsible for evaluation/reevaluation of needs-based eligibility for 1915(i) HCBS State plan services. Qualifications are:

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

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The process for evaluating whether customers meet the 1915(i) needs-based eligibility criteria is described below.

Referral

Referrals may come from hospitals, physicians, schools, nursing agencies, and the OA website.

Independent Assessment

An assessor at the OA performs the person-centered comprehensive assessment that is sent to the MA, along with supporting documentation, including medical reports. The assessment gathers information in the following areas: health, safety, welfare, community integration, social/emotional, educational, financial, and transition.

Evaluation Review and Determination

The OA submits the completed eligibility enrollment packet to the MA for review. A physician at the MA reviews the assessment and supporting documentation to determine whether the child meets the needs-based eligibility criteria as identified below. The MA has final approval of all eligibility determinations.

Reevaluation Process

The OA is responsible for maintain and updating the customer's assessment. The assessment is updated annually or more frequently if there is a substantial change in the customer's condition. The

OA will submit the updated assessment to the MA prior to the end of the customer's annual 1915(i) benefit eligibility period. The MA will complete a reevaluation of eligibility using the updated assessment. The OA and MA work together to assure the reevaluations are completed timely.

4. ☒ **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The State has developed eligibility criteria in accordance with 42 CFR 441.715.

Eligibility is based on the need for in-home shift nursing, which includes 1915(i) HCBS state plan CNA services by the legally responsible family caregivers, is determined by a MA physician consultant's review of medical records.

6. ☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Customer has documented skilled nursing needs that require ongoing nursing interventions and CNA services by the legally responsible family caregivers. Requires a prescription from a physician stating that the customer requires shift nursing services in the home.	Persons with Disabilities (IL0142): Individuals must meet all the following: <ul style="list-style-type: none">• Medical determination of a diagnosed, severe disability, which is expected to last for 12 months or for the duration of life; and,• Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment (see description below). Persons with Brain Injury (BI) (IL0329): Individuals must meet all the following:	Support Waiver for Children and Young Adults with Developmental Disabilities (DD) (IL0464) and the Adults with DD Waiver (IL0350): Individuals must meet all the following: <ul style="list-style-type: none">• Medical determination of a diagnosed intellectual/developmental disability (/DD) or related condition; and,• Assessed as eligible for an institutional level of care for persons with intellectual disabilities	Medically Fragile, Technology Dependent (IL0278): Individuals must meet all the following: <ul style="list-style-type: none">• Requires level of care appropriate to a hospital or skilled nursing facility; and,• Meets the minimum score on the Illinois approved Level of Care (LOC) tool. The LOC tool measures the technology and care needs of the child. Children must have both at least one technology and at least one care need. The assessed technology

<p>The amount, duration, and/or frequency of these services are dependent on continued authorization by the physician, and an independent assessment of medical necessity by the MA.</p>	<ul style="list-style-type: none"> • Have functional limitations directly resulting from an acquired brain injury as documented by a physician or neurologist; and, • Be at risk of nursing facility placement as measured by the DON. <p>Persons who are Elderly (IL0143): Individuals must be at risk of nursing facility placement as measured by the DON.</p> <p>Persons with HIV/ AIDS (IL0202) Individuals must meet all the following:</p> <ul style="list-style-type: none"> • Medical determination of HIV or AIDS with severe functional limitations, which is expected to last for at least 12 months or for the duration of life; and, • Be at risk of nursing facility placement as measured by the DON (see description below). <p>Supportive Living Program (IL0326) Individuals must be found to need of nursing facility level of care and Supportive Living Program is appropriate to meet the person's needs.</p> <p>DON Assessment The DON includes a Mini-Mental State Exam (MMSE) and a functional status section that assesses both ADLs and IADLs. The ADLs and IADLs</p>	<p>or conditions similar to intellectual disabilities using a combination of assessments, including the Inventory for Client and Agency Planning (ICAP). The ICAP measures the adaptive behavior and maladaptive behavior needs of individuals with I/DD. Adaptive behavior needs are measured across the following domains: motor skills, social and communication skills, personal living skills, and community living skills.</p> <p>Residential Waiver for Children & Young Adults with Developmental Disabilities (IL0473): Individuals must meet all the following:</p> <ul style="list-style-type: none"> • At risk of placement in an Intermediate Care Facility for persons with Developmental Disabilities (ICF/DD); and, • Assessed as eligible for an institutional level of care for persons with intellectual disabilities or conditions similar to intellectual disabilities using a combination of assessments, including the Inventory for Client and Agency Planning (ICAP). The ICAP measures the adaptive behavior and 	<p>needs reflect the risk of death or disability if the technology is not provided, as well as the degree of care needed to operate the technology. The assessed care needs reflect the ongoing treatment needs for caring for the child's serious illness and is scored to reflect the time and/or frequency needed to perform the skill, the need for care, and the ability of the child to complete the care on their own.</p> <p>Hospital Individuals must meet all the following:</p> <ul style="list-style-type: none"> • Meets the InterQual criteria for acute hospital care based on the primary diagnosis and clinical presentation of the customer; and, • Condition requires 24/7 medically monitored care for the treatment of an acute illness or injury, as certified by a physician. <p>Long Term Acute Care (LTAC) Hospital Individuals must meet all the following:</p> <ul style="list-style-type: none"> • Meets the InterQual criteria for long-term acute hospital care based on the primary diagnosis and clinical presentation of the customer; and,
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	<p>assessed 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. The MMSE measures cognitive functioning of the customers. 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.</p>	<p>maladaptive behavior needs of individuals with I/DD. Adaptive behavior needs are measured across the following domains: motor skills, social and communication skills, personal living skills, and community living skills.</p>	<ul style="list-style-type: none"> Condition requires extended 24/7 medically monitored care for the ongoing treatment of a serious medical condition, as certified by a physician.
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*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☒ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Services are targeted to children under 21 years of age.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (*Specify the phase-in plan*):

(By checking the following box the State assures that):

8. ☒ **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the customer requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i	Minimum number of services.
	The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: <div>1</div>
ii.	Frequency of services. The state requires (select one):
	<input checked="" type="radio"/> The provision of 1915(i) 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 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The 1915(i) HCBS state plan benefit for CNA services by the legally responsible family caregivers will be furnished to eligible customers who reside and receive HCBS in their home or in the community, not in an institution or institution-like setting.

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

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

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.
2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).
3. ☒ The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.
4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.**
There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

OA Care Coordinators, responsible for completing the customer's face-to-face assessment, must be credentialed as one of the following:

Nurse Care Coordinator:

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

Social Worker Care Coordinator:

1. Master's degree in social work or social service administration, and one of the following:
Current State of Illinois Licensure as a Licensed Social Worker or Licensed Clinical Social Worker, or two years (24 months) of progressively more responsible full-time experience in social work in a medical/clinical or other social service agency setting.

2. Bachelor of Arts Degree or Science from an accredited college or university in social science, social work or in a related field, and two years (24 months) of progressively more responsible full-time experience in social work in a medical/clinical or other social service agency setting.

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

- 5. Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

OA Care Coordinators, responsible for developing service plans, must be credentialed as one of the following:

Nurse Care Coordinator:

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

Social Worker Care Coordinator:

1. Master's degree in social work or social service administration, and one of the following: Current State of Illinois Licensure as a Licensed Social Worker or Licensed Clinical Social Worker, or two years (24 months) of progressively more responsible full-time experience in social work in a medical/clinical or other social service agency setting.

2. Bachelor of Arts Degree or Science from an accredited college or university in social science, social work or in a related field, and two years (24 months) of progressively more responsible full-time experience in social work in a medical/clinical or other social service agency setting.

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

- 6. Supporting the Customer in Development of Person-Centered Service Plan.** Supports and information are made available to the customer (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the customer's authority to determine who is included in the process):*

(a) Specify the supports and information made available

The Person-Centered Plan (PCP) begins with an assessment conducted by an OA Care Coordinator, who is not linked to any provider of service. The Care Coordinator uses a holistic approach to person-centering planning and encourages customer/authorized representative involvement in development of the PCP. Significant training is provided to Care Coordinators on the PCP.

Routine practice of the OA Care Coordinator includes asking the customer and their family or legal representative who they would like to attend their PCP development session. The customer, their family or legal representative, and other individuals from the customer's support network, if the customer/family/legal representative chooses, work together with the Care Coordinator to develop the PCP.

As the date and time is set for the development of the PCP, the OA Care Coordinator makes every accommodation possible to satisfy and include all persons identified by the customer and their family. It is expected that all conversations between the OA Care Coordinator and the customer are customer-focused, constantly reinforcing that planning is a collaborative effort, enabling the

customer to lead the process to the best of their abilities and that the outcome of the process is a PCP that is holistic, owned, is agreed to by the customer and their family and is reflective of their needs, preferences, person-centered goals, safety, welfare, and health status.

The Care Coordinator provides information and support to enable the customer and their family or legal representative to participate in and direct the PCP planning process. The customer is informed of the types of services available, as well as options of all willing and qualified providers. The Care Coordinator also shares helpful resources that are not covered by Medicaid. The options discussed and the choices made are documented as part of the PCP planning process.

As noted above, the holistic person-centered approach is designed for care coordination to encompass the comprehensive assessment of the customer's situation and circumstances related to all factors contributing to health, welfare, safety, community integration, quality of life, and the customer's vision for his/her quality of life. The PCP begins with an initial comprehensive assessment of the customer's and family's strengths and needs. Through this initial assessment, the Care Coordinator builds a relationship with the customer and the family by gaining an understanding of their perspectives, gathering information, identifying their strengths, and understanding the customer and family's needs and goals. The assessment gathers data in the following area: health, social/emotional, educational, financial, and transition. The assessment process is the discovery portion of the PCP that ultimately leads the customer and the family in the development and implementation of the PCP. Direct service providers do not play a direct role in the development of the PCP, nor do they attend any planning meetings, unless the customer or their legal representative requests their participation.

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

The PCP is written in plain language and in a manner easily understood by the customer. The written plan may be produced in other formats, such as pictures, DVD, etc., to accommodate specific needs of the customer; however, the PCP must exist in written format. The customer, their legal representative, if applicable, and the Care Coordinator all sign the PCP. Providers that participate in the development of the PCP must also sign the plan. If the legally responsible family caregiver is providing home health aide services, they may not sign the PCP. The customer must select another person to sign.

The PCP is the result of this comprehensive assessment, and it captures the customer's life goals and desires. It identifies supports, both Medicaid services and non-covered services, to assist the customer in actualizing these goals and desires. The written documentation in the development of the PCP and other assessment forms utilized during the assessment/reassessment processes demonstrate that the customer exercised choice in the decision-making process. Once the PCP is developed by the Care Coordinator and the customer, it is signed by the customer or legal representative, if applicable, the Care Coordinator, and sent to all providers listed in the PCP.

The customer, or their legal representative, if applicable, and direct service providers responsible for the PCP's implementation are given a written copy of the plan by the Care Coordinator when it is developed and whenever it is updated. The customer and their legal representative, if applicable, may also obtain a new copy of the PCP by requesting it of the Care Coordinator. The Care Coordinator attempts to contact customers/families, at least every 30 days. Although contacts are attempted every 30 days, a successful contact is required every 90 days. During these contacts, progress towards goals is discussed and updates are made as needed. Annually, the customer is

informed about the process to request updates to the PCP and is informed of their right to request a revision to the PCP at any time.

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

This is to be given to all customers at the time of assessment and reassessment. As described in (a) above, the OA Care Coordinator routinely inquires and documents in the PCP the customer and family's authority to determine who is included in the process.

7. Informed Choice of Providers. *(Describe how customers are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Care Coordinators assist customers with selecting their nursing agency provider. Customers are informed they may change service providers at any time. The legally responsible family caregiver who is providing family caregiver home health aide services will be an employee of a nursing agency. The OA provides a list of all approved nursing agency providers that serve customers in the geographical area to customers and families upon entry into the program, upon request and as the need to change providers arises. The list is continually updated by the OA.

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

The nursing agency chosen by the customer is contacted to determine whether they are willing to provide the service and able to meet the needs of the customer.

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

Customers and families may choose to change nursing agencies for a number of reasons. The OA Care Coordinators make every effort to personally assist customers and families to find a nursing agency to meet their needs.

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The OA is responsible for monitoring and reporting the performance measures related to PCP development and implementation.

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

9. Maintenance of Person-Centered 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 §74.53. Service plans are maintained by the following *(check each that applies)*:

<input type="checkbox"/>	Medicaid agency	<input checked="" type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (specify):				

Services

1. **State plan HCBS.** (Complete the following table for each service. Copy table as needed):

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):			
Service Title:	Family caregiver home health aide services		
Service Definition (Scope):			
<p>Family caregiver home health aide services are an extended version of the home health aide services available under the Medicaid State Plan. Family caregiver home health aide services are provided by a legally responsible family caregiver employed by an enrolled nursing agency, are delivered on an hourly shift basis, and focus on the customer's long-term habilitative needs.</p> <p>The legally responsible family caregiver serving as a home health aide provides basic services within their scope of training and certification, including assisting with the assessment and care planning, nutrition and elimination needs, mobility, personal hygiene, and grooming, comfort, and anxiety relief, promoting customer safety and environmental cleanliness. Duties may include but are not limited to: checking and recording vital signs, measuring height and weight, measuring intake and output, collecting specimens, feeding, assisting with bed pans, assisting with colostomy care, turning and positioning, transferring to wheelchairs/stretchers, bathing, assisting with oral hygiene, shaving, preparing hot and cold applications, making beds, observing response to care, reporting and recording observations of person's condition, cleaning and caring for equipment, and transporting.</p>			
Additional needs-based criteria for receiving the service, if applicable (specify):			
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration, and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.			
(Choose each that applies):			
<input type="checkbox"/>	Categorically needy (specify limits):		
<input checked="" type="checkbox"/>	Medically needy (specify limits):		
	This service requires an order from a physician stating that the customer requires home health services. Other documents required include medical reports, and reports of hospitalizations. The amount, duration and/or frequency of these services are dependent on continued authorization by the physician, and an independent assessment of medical necessity by the Medicaid agency.		
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):

Home Nursing Agency	Providers must be licensed in the State of Illinois as a Home Nursing Agency	N/A	Home nursing agency provider must meet requirements for Nursing Agencies participating with the Illinois Department of Healthcare and Family Services Home Care Program. Staff delivering family caregiver home health aide services must be a legally responsible caregiver selected and approved by the customer and who is credentialed as a Certified Nurse Aide (CNA).
Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>		Frequency of Verification <i>(Specify):</i>
Home Nursing Agency	OA		At the time of enrollment and annually
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/> Customer-directed		<input checked="" type="checkbox"/> Provider managed	

2. ☒ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Legally responsible family caregivers may be paid for providing 1915(i) HCBS home health aide services when employed as a Certified Nurse Aide (CNA) by a home nursing agency approved by the MA and OA. The nursing agency is responsible for hiring, scheduling, supervising, and monitoring of CNAs. The legally responsible family caregiver must meet the same criteria and qualifications as any other CNA employed by the agency. Services must be provided under a physician's order, as well as included in the customer's person-centered plan (PCP).

The nursing agency conducts onsite supervisory visits of CNAs every 60 days as required by administrative rule. During the supervisory visit, the customer's general condition and home

environment will be assessed to ensure services are being provided in accordance with the customer's PCP and to ensure that payments are made only for services rendered.

Limitations:

- A legally responsible family caregiver may not work more than 16 hours/day, with 8-hour break in between shifts.
- Services must not exceed the amount, duration, and frequency recommended by a physician and authorized by the MA.

Specific requirements for paying legally responsible family caregiver are as follows:

- The legally responsible family caregiver must have completed the State approved Certified Nursing Assistant Training and be certified as a nurse aide with the Illinois Department of Public Health.
- The legally responsible family caregiver must be employed and supervised by a nursing agency enrolled with the MA and OA and assigned to staff the case.
- The legally responsible family caregiver must comply with all the nursing agency's policies, procedures, and documentation requirements.
- The nursing agency must develop and document additional assurances and monitoring oversight to ensure that an appropriate back-up coverage plan is in place and such plan must include unpaid trained caregivers.
- A legally responsible family member with a history of abuse, neglect, or exploitation are not eligible to provide 1915(i) HCBS State Plan home health aide services.
- A legally responsible family member that has committed Medicaid fraud is not eligible to provide 1915(i) HCBS State Plan home health aide services.

Customer-Direction of Services

Definition: Customer-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Customer-Direction. (Select one):

<input checked="" type="radio"/>	The state does not offer opportunity for customer-direction of State plan HCBS.
<input type="radio"/>	Every customer in State plan HCBS (or the customer's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for customers who decide not to direct their services.
<input type="radio"/>	Customers in State plan HCBS (or the customer's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. <i>(Specify criteria):</i>

2. Description of Customer-Direction. (Provide an overview of the opportunities for customer-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how customers 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 approach to customer-direction):

N/A

3. Limited Implementation of Customer-Direction. *(Customer direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

<input type="radio"/>	Customer direction is available in all geographic areas in which State plan HCBS are available.
<input type="radio"/>	Customer-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the state affected by this option):</i>

4. Customer-Directed Services. *(Indicate the State plan HCBS that may be customer-directed and the authority offered for each. Add lines as required):*

Customer-Directed Service	Employer Authority	Budget Authority
N/A	<input type="checkbox"/>	<input type="checkbox"/>
N/A	<input type="checkbox"/>	<input type="checkbox"/>

5. Financial Management. *(Select one) :*

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ Customer-Directed Person-Centered Service Plan. *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Customer-Direction. *(Describe how the state facilitates an individual's transition from customer-direction, and specify any circumstances when transition is involuntary):*

N/A

8. Opportunities for Customer-Direction

- a. Customer-Employer Authority** (individual can select, manage, and dismiss State plan HCBS providers). *(Select one):*

<input checked="" type="radio"/>	The state does not offer opportunity for customer-employer authority.
<input type="radio"/>	Customers may elect customer-employer Authority (<i>Check each that applies</i>):
<input type="checkbox"/>	Customer/Co-Employer. The customer (or the customer's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of customer-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the customer in conducting employer-related functions.
<input type="checkbox"/>	Customer/Common Law Employer. The customer (or the customer's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the customer's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the customer in conducting employer-related functions.

- b. **Customer–Budget Authority** (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one*):

<input checked="" type="radio"/>	The state does not offer opportunity for customers to direct a budget.
<input type="radio"/>	Customers may elect Customer–Budget Authority.
	Customer-Directed Budget. (<i>Describe in detail the method(s) that are used to establish the amount of the budget over which the customer has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each customer; and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.</i>):
	Expenditure Safeguards. (<i>Describe the safeguards that have been established for the timely prevention of the premature depletion of the customer-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.</i>

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) customers; b) are updated annually; and (c) document choice of services and providers.

Requirement	
1a) Service plans address assessed needs of 1915(i) customers	
Discovery	
Discovery Evidence (Performance Measure)	Number and percent of 1915(i) customers' Person Centered Plans (PCPs) that address all needs identified by the assessment. N: Number of 1915(i) customers' PCPs that address all needs identified by the assessment. D: Total number of 1915(i) customers' PCPs reviewed.
Discovery Activity (source of data & sample size)	Source of Data = Record review Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of customers enrolled in the 1915(i) at the point in time the sample is drawn.
Monitoring Responsibilities (agency or entity that conducts discovery activities)	OA
Frequency	Quarterly and Annually.
Remediation	
Remediation Responsibilities (who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	OA and MA If PCP does not address all needs identified by the assessment, the OA will require the PCPs be corrected and the OA will provide training of Care Coordinators. Remediation must be completed within 60 days.
Frequency (of Analysis and Aggregation)	Quarterly and Annually.

Requirement	
1b) Service plans are updated at least annually.	
Discovery	
Discovery Evidence	Number and percent 1915(i) customers who have their Person Centered Plan (PCP) updated at least every 12 months.

	<i>(Performance Measure)</i>	<p>N: Number of 1915(i) customers who have their PCP updated at least every 12 months.</p> <p>D: Total number of 1915(i) customers PCPs reviewed.</p>
	Discovery Activity <i>(source of data & sample size)</i>	<p>Source of Data = Record review</p> <p>Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of customers enrolled in the 1915(i) at the point in time the sample is drawn.</p>
	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	OA
	Frequency	Quarterly and Annually.
Remediation		
	Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>OA and MA</p> <p>OA will require completion of overdue PCPs and provide training the Care Coordinator. Remediation must be completed within 60 days.</p>
	Frequency <i>(of Analysis and Aggregation)</i>	Quarterly and Annually.
Requirement		
1c) Service plans document choice of services and providers.		
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of 1915(i) customers Person-Centered Plan (PCP) that document choice of services and providers.</p> <p>N: Number of 1915(i) customers Person-Centered Plan (PCP) that document choice of services and providers.</p> <p>D: Total number of 1915(i) customers PCPs reviewed.</p>
	Discovery Activity <i>(source of data & sample size)</i>	<p>Source of Data = Record review</p> <p>Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of customers enrolled in the 1915(i) at the point in time the sample is drawn.</p>
	Monitoring Responsibilities	OA

	<i>(agency or entity that conducts discovery activities)</i>	
	Frequency	Quarterly and Annually
Remediation		
	Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	OA and MA The OA will assure that choice of services and providers was provided as shown by the correction of documentation to indicate customer choice. The OA may also provide training to Care Coordinators. Remediation must be completed within 60 days.
	Frequency <i>(of Analysis and Aggregation)</i>	Annually.

2. **Eligibility Requirements:** (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

Requirement	2a) An evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of applicants where an evaluation for 1915(i) State Plan HCBS eligibility was provided when there is reasonable indication that 1915(i) services may be needed in the future. N: Number of applicants where an evaluation for 1915(i) State Plan HCBS eligibility was provided when there is reasonable indication that 1915(i) services may be needed in the future. D: Total number of 1915(i) State Plan HCBS applicants.
Discovery Activity <i>(source of data & sample size)</i>	Source of Data = OA Eligibility Report Sample Size = 100%
Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	OA
Frequency	Annually and Continuously and Ongoing

Remediation	
Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	OA and MA 1. Eligibility assessment 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.
Frequency <i>(of Analysis and Aggregation)</i>	Quarterly and Annually
Requirement	2b) The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of initial 1915(i) eligibility determinations and annual redeterminations where the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately. N: Number of initial 1915(i) eligibility determinations and annual redeterminations where the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately. D: Total number of initial 1915(i) eligibility determinations and annual determinations completed.
Discovery Activity <i>(source of data & sample size)</i>	Source of Data = MA eligibility report Sample Size = 100% review
Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	MA
Frequency	Continuously and Ongoing and Annually.
Remediation	
Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	OA and MA If it is discovered that the eligibility assessment does not support eligibility, the MA will complete a plan of correction to include a reassessment or justification if in error. If the justification is inadequate and/or the reassessment does not result in the customer being eligible, the 1915(i) eligibility will be discontinued, and the OA will assist the customer with accessing other supports and services. Federal claims will be adjusted, and the MA will provide technical assistance or training. Remediation must be completed within 60 days.

Frequency (of Analysis and Aggregation)	Annually.
Requirement	2c) The 1915(i)-benefit eligibility of enrolled customers is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence (Performance Measure)	<p>Number and percent of 1915(i) enrolled customers who's eligibility was reevaluated at least annually, as specified in the approved state plan for 1915(i) HCBS.</p> <p>N: Number of 1915(i) enrolled customers who's eligibility was reevaluated at least annually, as specified in the approved state plan for 1915(i) HCBS.</p> <p>D: Total Number of 1915(i) enrolled customers who had an eligibility reassessment due.</p>
Discovery Activity (source of data & sample size)	<p>Source of Data = MA eligibility report</p> <p>Sample Size = 100% review</p>
Monitoring Responsibilities (agency or entity that conducts discovery activities)	MA
Frequency	Annually and Continuously and Ongoing.
Remediation	
Remediation Responsibilities (who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	<p>OA and MA</p> <p>1. Eligibility assessment is completed/corrected upon discovery; 2. If eligible, no additional correction required; 3. If ineligible, billing, and claims adjusted; 4. Customer receives assistance with accessing other supports and services; Remediation must be within 60 days.</p>
Frequency (of Analysis and Aggregation)	Quarterly and Annually.

3. Providers meet required qualifications.

Requirement	3a) Providers meet required qualifications (initially)
Discovery	
Discovery Evidence (Performance Measure)	<p>Number and percent of new providers who meet the provider requirements.</p> <p>N: Number of new providers who meet the provider requirements.</p> <p>D: Total number of new providers.</p>

	Discovery Activity <i>(source of data & sample size)</i>	Source of Data = Nursing agency list of new CNAs.. Sample Size = 100% review
	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	MA
	Frequency	Continuously and ongoing.
Remediation		
	Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	OA and MA If a new provider fails to meet initial provider requirements, the OA informs the nursing agency, and the employee is terminated.
	Frequency <i>(of Analysis and Aggregation)</i>	Quarterly, Annually, and Continuously and Ongoing

Requirement		3b) Providers meet required qualifications (ongoing)
Discovery		
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of enrolled providers who continue to meet required qualifications. N: Number of enrolled providers who continue to meet required qualifications. D: Total number enrolled providers.	
Discovery Activity <i>(source of data & sample size)</i>	Source of Data = H Nursing agency list of ongoing CNAs. Sample Size = 100% review	
Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	MA	
Frequency	Continuously and ongoing.	
Remediation		
Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MA and OA If a new provider fails to meet initial provider requirements, the OA informs the nursing agency, and the employee is terminated.	

	<i>required timeframes for remediation)</i>	
	Frequency <i>(of Analysis and Aggregation)</i>	Quarterly and Annually

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

Requirement		4) Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	<p>The number and percent of customers whose person-centered plan (PCP) indicate the customer resides in and receives services in a compliant home and community-based setting as specified by this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).</p> <p>N = Number of customers whose PCP documents the customer resides in and receives services in a compliant home and community-based setting as specified by this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).</p> <p>D = Total number of 1915(i) PCP reviewed.</p>
	Discovery Activity <i>(source of data & sample size)</i>	<p>Source of Data = Record review</p> <p>Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.</p>
	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	OA
	Frequency	Annually
Remediation		
	Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>MA and OA</p> <p>If a Corrective Action Plan (CAP) is needed, it must be provided to the OA within 15 business days. All CAPs are subject to HFS approval. Remediation must be completed within 90 days after the CAP is approved by HFS.</p>
	Frequency <i>(of Analysis and Aggregation)</i>	Annually

5. The SMA retains authority and responsibility for program operations and oversight.

Requirement		5a) The MA retains authority and responsibility for program operations and oversight.
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of quarterly Quality Management Committee (QMC) meetings between OA and MA where the OA's quality performance data for the 1915(i) HCBS was reviewed.</p> <p>N: Number of quarterly QMC meetings between OA and MA where the OA's quality performance data for the 1915(i) HCBS was reviewed.</p> <p>D: Total number of QMC meetings where OA quality performance data for the 1915(i) HCBS was reviewed.</p>
	Discovery Activity <i>(source of data & sample size)</i>	<p>Source of Data = Meeting Log</p> <p>Sample Size = 100% review</p>
	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	MA
	Frequency	Continuously and Ongoing
Remediation		
	Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>MA</p> <p>The MA will require completion of overdue quality performance data reports. The OA will submit a plan of correction within 30 days.</p>
	Frequency <i>(of Analysis and Aggregation)</i>	Continuously and Ongoing

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) customers by qualified providers.

Requirement		6a) The MA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) customers by qualified providers.
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	The number and percent of claims for 1915(i) services paid for customers who were eligible for the 1915(i) benefit on the date the service was delivered.

		<p>N = Number of claims for 1915(i) services paid for customers who were eligible for the 1915(i) benefit on the date the service was delivered.</p> <p>D = Total number of claims paid for 1915(i) services furnished.</p>
	Discovery Activity <i>(source of data & sample size)</i>	<p>Source of Data = MA Data Warehouse</p> <p>Sample Size = 100% review</p>
	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	MA
	Frequency	Annually
Remediation		
	Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>OA and MA</p> <p>The MA will require the OA to void the federal claim for services provided prior to the customer's eligibility for 1915(i) HCBS services. The MA will adjust the federal claim for services provided by the OA prior to the customer's eligibility. Remediation must be completed within 30 days.</p>
	Frequency <i>(of Analysis and Aggregation)</i>	Annually.
Requirement		
		6b) The MA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) customers by qualified providers.
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of claims paid according to the published fee schedule during the review period.</p> <p>N = Number of claims paid according to the published fee schedule during the review period.</p> <p>D = Total number of claims paid during the review period.</p>
	Discovery Activity <i>(source of data & sample size)</i>	<p>Source of Data = MA Data Warehouse</p> <p>Sample Size = 100% review.</p>
	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	OA and MA
	Frequency	Annually

Remediation	
Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	OA and MA The MA will require the OA to correct the incorrect rate and if needed will correct the rate in its MMIS system. If necessary, the MA will also adjust federal claims submitted. Remediation must be completed within 30 days.
Frequency <i>(of Analysis and Aggregation)</i>	Annually

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Requirement	7a) The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of records reviewed where the customer/legal representative received information about how and to whom to report incidents of abuse, neglect, exploitation, and the use of restraints at the time of each assessment. N: Number of records reviewed where the customer/legal representative received information about how and to whom to report incidents of abuse, neglect, exploitation, and the use of restraints at the time of each assessment. D: Total number of records reviewed.
Discovery Activity <i>(source of data & sample size)</i>	Source of Data = Record reviews Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual customers enrolled in the 1915(i) at the point in time the sample is drawn.
Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	MA and OA
Frequency	Quarterly and Annually
Remediation	
Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	OA and MA The OA will assure that customers/legal representative know how to report abuse, neglect, exploitation, and the use of restraints. This will be demonstrated by collection of case work documentation reflecting customer's/ legal

	<i>required timeframes for remediation)</i>	representative's awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.
	Frequency (of Analysis and Aggregation)	Quarterly and Annually
Requirement		
Discovery		
	Discovery Evidence (Performance Measure)	<p>Number and percent of substantiated incidents of abuse, neglect, exploitation, and/or the use of restraints reported to the OA that were reviewed/investigated within the required timeframes.</p> <p>N: Number of substantiated incidents of abuse, neglect, exploitation, and/or the use of restraints reported to the OA that were reviewed/investigated within the required timeframes.</p> <p>D: Total number of substantiated incidents of abuse, neglect, exploitation, and/or the use of restraints reported to the OA.</p>
	Discovery Activity (source of data & sample size)	<p>OA Report</p> <p>Sample Size = 100%</p>
	Monitoring Responsibilities (agency or entity that conducts discovery activities)	OA
	Frequency	Quarterly and Annually
Remediation		
	Remediation Responsibilities (who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	<p>MA and OA</p> <p>The OA will review all substantiated incidents of abuse, neglect, exploitation, and the use of restraints to ensure remediation has occurred. The remediation action is based on circumstances and identified trends, i.e. changes in customer's PCP, corrective action plans, provider training, sanction, or termination of provider.</p>
	Frequency (of Analysis and Aggregation)	Quarterly and Annually

Requirement		7b) The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery		
	Discovery Evidence (Performance Measure)	Number and percent of substantiated incidents of abuse, neglect, exploitation, and the use of restraints reported to the OA where appropriate actions were taken to address the incident.

		<p>N: Number of substantiated incidents of abuse, neglect, exploitation, and the use of restraints reported to the OA where appropriate actions were taken to address the incident.</p> <p>D: Total number of substantiated incidents of abuse, neglect, exploitation, and the use of restraints reported to the OA.</p>
	Discovery Activity <i>(source of data & sample size)</i>	<p>Source of Data = OA Report</p> <p>Sample Size = 100% review</p>
	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	OA
	Frequency	Quarterly and Annually
Remediation		
	Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>MA and OA</p> <p>The OA will review all substantiated incidents of abuse, neglect, exploitation, and the use of restraints reported to the OA to ensure remediation has occurred to address the incident. Remediation actions are based on circumstances and identified trends, i.e. changes in customer's PCP, corrective action plans, provider training, sanction, or termination of provider.</p>
	Frequency <i>(of Analysis and Aggregation)</i>	Annually
Remediation		
	Remediation Responsibilities <i>(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	OA
	Frequency <i>(of Analysis and Aggregation)</i>	Quarterly and Annually

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input type="checkbox"/>	HCBS Case Management
<input type="checkbox"/>	HCBS Homemaker
<input checked="" type="checkbox"/>	HCBS Home Health Aide by Legally Responsible Adult HCBS home health aide rates are on a fee schedule and were established by comparing the services to similar covered Medicaid services. Reimbursement is made at the lesser of the usual and customary charge to the general public or the maximum fee schedule rate established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate will be set as of January 1, 2025, and is effective for services provided on or after that date. All rates are published on the Department's website located at https://hfs.illinois.gov/medicalproviders/medicaidreimbursement.html .
<input type="checkbox"/>	HCBS Personal Care
<input type="checkbox"/>	HCBS Adult Day Health
<input type="checkbox"/>	HCBS Habilitation
<input type="checkbox"/>	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)
<input type="checkbox"/>	Other Services (specify below)