Application for a Â§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 waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

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

B. Program Title:
Persons with HIV or AIDS

C. Waiver Number:IL.0202
Original Base Waiver Number: IL.0202.

D. Amendment Number:IL.0202.R07.04

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

07/01/25

Approved Effective Date: 07/01/25
Approved Effective Date of Waiver being Amended: 10/01/23

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:

1. Request approval for an increase in the Individual Provider (IP) rates and Respite Individual Provider (IP) rates. The rates will increase in the following manner effective July 1, 2025, in response to the Service Employee International Union (SEIU) Collective Bargaining Agreement.

Individual Provider and Respite Individual Provider increase to $18.75 an hour.
Individual Provider (CNA) and Respite Individual Provider (CNA) increase to $21.75 an hour.
Individual Provider (LPN) and Respite Individual Provider (LPN) increase to $28.75 an hour.
Individual Provider (RN) and Respite Individual Provider (RN) increase to $35.50 an hour.

2. Update Appendix B-2-a-Other to increase the service cost maximum (SCM) table to account for the 7/1/2025 rate increases. The new SCM will be effective 7/1/2025, or upon CMS approval.

3. Edit Appendix B-2-c to clarify the procedure for establishing the exceptional care rate. The rate of 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.

4. Edit appendix C-1/C-3 Environmental Accessibility Adaptations and Specialized Medical Equipment and Supplies services to reference the specific Administrative Code for purchase limits and timeframes instead of specifying the specific details. The State intends to change the purchase limits in Administrative Code from $25,000 every 5 years to $26,300 every 3 years as identified in 89 Ill. Adm. Code 686.605(c) and 89 Ill. Adm Code 686.705(d).

5. Edited all services in Appendix C-1 to add appropriate taxonomy codes previously omitted.

6. Edit appendix I-2-a, to reflect the Individual Provider and Respite Individual Provider rates as defined above in #1 and updated the Environmental Accessibility Adaptations and Specialized Medical Equipment and Supplies services to reduce the number of required bids from three to two for any item costing more than $5,000, which was increased from $1,500 in this amendment.

7. Edit Appendix J-2-c-i to reflect the increase in Individual Provider and Respite rates effective 07/01/2025, or up on CMS approval.

8. No changes were made to Appendix J-2-d related to the rate increases for WY2 through WY5 since the rate increases were less than 10%, per CMS guidance, and the current waiver projections were sufficient to cover the increases.

No funding from section 9817 of the American Rescue Plan Act of 2021 (ARP) is being used for the implementation of the changes under this amendment.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	
☐ **Appendix A ? Waiver Administration and Operation**	
☒ **Appendix B ? Participant Access and Eligibility**	2-a-Other, B-2-c

Component of the Approved Waiver	Subsection(s)
☒ Appendix C ? Participant Services	C-1 (Env. Adapt. Limits) & Taxonomy
☐ Appendix D ? Participant Centered Service Planning and Delivery	
☐ Appendix E ? Participant Direction of Services	
☐ Appendix F ? Participant Rights	
☐ Appendix G ? Participant Safeguards	
☐ Appendix H	
☒ Appendix I ? Financial Accountability	2-a
☒ Appendix J ? Cost-Neutrality Demonstration	2-c-i

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

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

  Specify:

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

1. Request Information (1 of 3)

A. The **State** of **Illinois** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Persons with HIV or AIDS

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IL.0202
Waiver Number:IL.0202.R07.04
Draft ID: IL.011.07.04

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/23
Approved Effective Date of Waiver being Amended: 10/01/23

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: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 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 HIV or AIDS

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

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

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

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

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

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

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

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

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

The State enrolls Medicaid 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 state wideness, freedom of choice or comparability. The authority will not be used to mandate enrollment of Medicaid beneficiaries who are Medicare eligible, or who are First Nation/Native Americans (Indians), except for voluntary enrollment as indicated in subsection E (Populations and Geographic Area) of the SPA.

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

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

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

Specify the program:

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

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Persons with HIV or AIDS waiver was initially approved by the Centers for Medicare and Medicaid Services (CMS) in 1990. This program is one of three home and community-based services (HCBS) waiver programs operated by the Department of Human Services, Division of Rehabilitation Services (DHS DRS). The Department of Healthcare and Family Services (HFS), as the single state Medicaid agency (MA), administers the waiver.

The MA and DHS DRS, as the operating agency (OA), have entered into an interagency agreement that outlines the respective roles and responsibilities relative to all three DHS DRS operated HCBS waiver programs. The interagency agreement is reviewed annually and updated as needed.

The purpose of the waiver is to serve persons with HIV or AIDS who are at risk for nursing facility level of care. The waiver allows customers to remain in their homes and receive a wide array of services.

The waiver is based on an independent living philosophy that encourages customers to direct their own care. The most used service in the waiver is the Individual Providers (IPs) as it allows customers more privacy in directing their own care. If a waiver customer chooses this service, he or she may hire, train, and, if necessary, terminate their individual provider or other individually hired provider such as a home health aide, licensed practical nurse, or registered nurse.

DHS DRS (OA) operates a payroll system for the individual providers that are hired by the waiver customers. Pay checks or direct deposits are processed every two weeks and the payroll system withholds unemployment, FICA, other employee benefits and other deductions as requested by the provider.

With this renewal, the OA is changing the name of the "AIDS Administration Unit" (AAU) to the "HSP Ashburn Unit". The name was changed due to concerns raised by customers and providers having to go to an office with “AIDS" in the title and to ensure customer/provider confidentiality. HSP Ashburn Unit staff are employed by the OA and are responsible for oversight of the contracted case management offices. The OA is also changing the name of the "Certified AIDS case managers" to "OA Case Managers". This again is to remove the reference to "HIV or AIDS" in their title and ensure customer/provider confidentiality.

There are thirty (30) contracted case management offices located statewide, that provide case management for fee-for-service (FFS) waiver customers. OA Case Managers are required to contact waiver customers at least once a month, with a face-to-face contact bi-monthly, to ensure the customer's needs are being met; services are provided in accordance with Person Centered Plan; to monitor the customer's health, safety and welfare; to follow-up on any identified issues; and to determine whether additional services are needed. In areas where contracted case management offices are not established, waiver customers access and receive waiver program services through HSP Rehabilitation Counselors employed through local OA offices. The OA Case Managers are the first line of contact for waiver customers and families. In addition to monitoring service delivery, and customer health and welfare, the case management duties include conducting assessments for eligibility and, for those funded by the OA, developing and overseeing the Person-Centered Plan, connecting customers with providers, and explaining rights and responsibilities.

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 into HealthChoice Illinois. Customers enrolled in the Medicare Medicaid Alignment Initiative (MMAI) are not impacted by HealthChoice Illinois. Illinois received approval from the federal Centers for Medicare and Medicaid Services (CMS) to jointly implement the MMAI program on February 22, 2013. Section 1915(c) waivers impacted by MMAI were amended at that time. MMAI contracts have been extended a couple times, and the current contract is set through December 31, 2025.

Customers who are transitioned into managed care services can access the same level of waiver services as provided by the OA through FFS. Care coordinators for MCOs are required to implement the same program guidelines as by OA HSP Rehabilitation Counselors and OA Case Managers as indicated above.

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 §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §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. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, 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 §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 02/20/2025, this proposed waiver amendment was sent to the tribal government and posted for public notice to the website of the Illinois Department of Healthcare and Family Services, http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx; providing for a 30-day comment period ending 03/22/2025.

The non-electronic method of public distribution occurred with postings at Illinois Department of Human Services local offices throughout the state (except in Cook County). In Cook County, the notice was available at the Office of the Director, Illinois Department of Healthcare and Family Services, 401 South Clinton Street, 1st Floor, Chicago, IL. Additionally, a phone number was provided within the notice to request a paper copy of the proposed waiver amendment. The public notice invited comments via email or regular mail. Finally, the Illinois Department of Human Services, Division of Developmental Disabilities, the operating agency of the HCBS Waiver for Adults with Developmental Disabilities, shared with their stakeholders and other interested parties.

Copies are also available at the following locations:

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

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

The State received two (2) public comments on this amendment:

1) (Paraphrased from 5-page document submitted by the Legal Council for Health Justice [LCHJ])
The LCHJ strongly supports the rate increases contained within these amendments to the HCBS waivers posted in on 2/20/25. We also support the updates to the service cost maximums, and the increased funding available for environmental accessibility adaptations and specialized medical equipment and supplies. We respectfully wish to add the following:

A) The Department Must Strengthen EPSDT Protections in Illinois
The State has an obligation to provide federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to all Illinois Medicaid members under 21. The state must provide the full array of EPSDT services to children, whether they are in a waiver or not. We respectfully encourage the State to set the goal of ensuring that the EPSDT pediatric benefit works smoothly for all kids, with a focus on those with high medical needs, those using waiver services, those seeking waiver services, and those with mental health or substance use disorder needs. We also encourage the Department to ensure that all aspects of the state's programs adhere to the September 2024 State Health Official Letter (SHO) #24-005, from the U.S. Centers for Medicare & Medicaid Services (CMS), titled "Best Practices for Adhering to EPSDT Requirements.

STATE RESPONSE: Thank you for taking the time to review the proposed waiver amendment. The waiver operating agency, the Department of Human Services/Division of Rehabilitation Services (DHS/DRS) continues to work with The Department of Healthcare and Family Services (HFS), and all of our waiver partners, towards the goal of ensuring that all eligible Illinois youth have access to EPSDT and waiver services.

B) MCOs Must Be Accountable for EPSDT Obligations in Illinois
For children on an HCBS waiver waiting list who are enrolled in managed care, the state must require MCOs to ensure that each such individual has a Plan of Service that is developed using a person-centered planning process and includes all covered services, EPSDT, in lieu of services, value-added benefits, and informal supports to address the child's needs, including private duty nursing (PDN) and personal care services (PCS). Because we have seen numerous examples of MCO plans failing to provide services to children, we strongly recommend strong grievance and appeals processes to ensure children receive EPSDT services within managed care.

STATE RESPONSE: Thank you for your comment. DHS/DRS is committed to making all appropriate services under the Home Services Program available to all eligible youth in our program. HFS is committed to working with the MCOs to make all covered services available to customers on an HCBS waiver waiting list.

C) The Existing Patchwork of PCS As a Waiver Service Is Not Serving Children
One pressing issue we routinely encounter involving the HCBS waivers is that children in Illinois seem to only be able to

access medically necessary PCS through the Home Services Program (HSP).

STATE RESPONSE: DRS has received your comment and appreciates your feedback.

D) Personal Care Services (PCS) and Private Duty Nursing (PDN) Must Be Provided Outside of Waiver Programs
EPSDT requires coverage of PDN and PCS when it is medically necessary. HCBS waivers should never delay or prevent EPSDT-eligible children from receiving these services. Eligible children should not need to apply for an HCBS waiver program to receive medically necessary PDN or PCS, and children receiving services through an HCBS waiver should not be prevented from receiving PDN or PCS through EPSDT. Children receiving services on HCBS waivers appear to be rarely offered PDN through EPSDT. Moreover, children seem to only be able to access medically necessary PCS through the HSP waiver.

STATE RESPONSE: HFS will take your feedback under review to better understand access and utilization of EPSDT-eligible children receiving PDN and PCS.

(CONTINUED IN MAIN OPTIONAL)

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

Address 2:

City: Springfield

State: **Illinois**

Zip: 62763

Phone:

(217) 782-6359 **Ext:** ☐ **TTY**

Fax:

(217) 782-5672

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:

Chapman

First Name:

Molly

Title:

Assistant Bureau Chief, Home Services Program

Agency:

Illinois Department of Human Services, Division of Rehabilitation Services

Address:

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

Signature: Pam Winsel

State Medicaid Director or Designee

Submission Date: May 15, 2025

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

Last Name: Cunningham

First Name: Kelly

Title: Medicaid Administrator

Agency: Healthcare and Family Services

Address: 201 South Grand Ave., East

Address 2:

City: Springfield

State: **Illinois**

Zip: 62763

Phone: (217) 782-2570 **Ext:** ☐ **TTY**

Fax: (217) 782-5672

E-mail: kelly.cunningham@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:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

CONTINUED FROM MAIN 6-I Public Comment

E) The Determination of Need (DON) Is an Inappropriate Tool for Evaluating Children
The DON tool is inappropriate for evaluating children's needs. Children with very severe disabilities receive low DON scores or be dissuaded from even applying for the waivers because of the expectation that they will receive low DON scores. The DON was not developed for children. We urge the Department to adopt methods that will accurately, consistently, and fairly determine health care and service needs across populations. It is time to stop using the DON and instead provide another child-appropriate method to evaluate children for waiver services.

STATE RESPONSE: DRS has received your comment and appreciates your input. We will be sure to share your concerns with relevant internal team members and with our partners at HFS.

Public Comment #2
(Paraphrased from 9-page document from The ARC of Illinois [The ARC])
We strongly support the rate increases contained within these amendments, as well as the resultant increases in service cost maximums. We also support the increased availability of Environmental Accessibility Adaptations and Specialized Medical Equipment by increasing the pot of money and renewing it every three years instead of every five years. These comments include the following:

A) The needs of children with severe disabilities in Illinois
We hear stories of parents of children under the age of 18 being discouraged from applying for waiver services. All three of these waivers allow children to enter at birth, however, it is not uncommon for families to be told that these waivers are only for adults. Illinois has gaps in services for children with disabilities, and these three waivers are critical to help fill those gaps. The Support Waiver for Children and Youth with Developmental Disabilities has an extensive waiting list for children. Because of this waiting list, many children with DD/ID or autism only have the option of applying for services through the three DRS waivers. Similarly, the Medically Fragile Technology Dependent waiver is only accessible to those with substantial medical technology, thereby excluding most children with severe physical disabilities in the state. It is critical that the DRS waivers appropriately accommodate children. Changes must be made to ensure that people of all ages are able to access the full range of services within these waivers.

STATE RESPONSE: Thank you for taking the time to review the proposed waiver amendment. The Department of Human Services/Division of Rehabilitation Services (DHS/DRS) continues to work with the Department of Healthcare and Family Services (HFS), and all of our waiver partners, towards the goal of ensuring that all eligible Illinois youth have access to waiver services.

B) Waivers must serve all participants fairly
Those under 18 are not being offered equivalent services to those over age 18 with similar disabilities. Children receive lower cost maximums and reduced services and often receive respite care only. This results in discrimination against a segment of waiver participants due to age. The state has expressed two reasons for limiting services for children: parental responsibility and low scores on the DON tool, both of which artificially and inappropriately reduce access for children.

STATE RESPONSE: Thank you for your comment. DHS/DRS is committed to making all appropriate services under the Home Services Program available to all eligible youth in our program.

C) Parental Responsibility of Children with Severe Disabilities
The State needs to recognizing that children with extraordinary needs require services that go far beyond typical parental responsibility.

STATE RESPONSE: DHS/DRS has received your comment and appreciates your feedback. Our Home Services Program strives to make all appropriate waiver services under our program available to all of our customers based on level of unmet need, including to those with extraordinary needs.

D) Assessment tool challenges in the pediatric population
The DON was never intended for use in children. The DON tool asks questions about functional limitations that are largely inapplicable to children resulting in children receiving very few points, no matter how severe their disability. We request that the state implement a child-appropriate tool for all children under the age of 18 seeking admission to any of these waivers.

STATE RESPONSE: Thank you for your feedback. We will be sure to share your concerns with relevant internal team members and with our partners at HFS.

E) EPSDT issues
There are two potential EPSDT problems with these three waivers. The first is that personal care services are being offered to children under the age of 21 through the waiver itself. These services must be provided through the state plan for children under the age of 21. The only exception is when these services legally cannot be provided through the state plan, such as when a parent of an individual under age 18 is being paid to provide them. Our understanding is that private duty nursing, when medically necessary, is currently being provided correctly through the state plan via the Home Care Program at DSCC; however, this service appears to be rarely offered to children and youth in these three waivers. The second issue is the incorrect use of the DON tool to limit the amount and scope of services for children under 21, as this tool may be used to award services such as personal care or nursing that should be covered under the state plan for children. The DON score is currently tied to a cost maximum that is then used to limit personal care hours; however, personal care hours cannot be limited arbitrarily since personal care is an EPSDT service. Under EPSDT, these services are not subject to arbitrary limitations, including cost maximums put in place based on the DON score. Instead, they must be provided in a sufficient quantity according to the medical necessity of the child. We request that the state ensures that all nursing and personal care services, as well as any other EPSDT-mandated state plan services, be provided to children under 21 through the state plan instead of the waiver, in the quantities that are medically necessary.

STATE RESPONSE: Thank you for your input. The DHS/DRS Home Services Program (HSP) program has nursing services available to eligible HSP customers, including to those under the age of 21. Again, we appreciate your feedback on use of the DON with children under 21 and will share it with relevant internal team members our and HFS partners for all to review.

F) Institutional Income and Resource rules for the medically needy
The Home Services Program uses unmatched state dollars to provide waiver like services to individuals who do not qualify financially for Medicaid and therefore these three waivers. By checking the box on each of these waivers to allow institutional income and resource rules for the medically needy to be employed instead, the state will have the opportunity to receive federal matching dollars for some individuals currently funded by state dollars only.

STATE RESPONSE: DHS/DRS is in receipt of your comments and will review internally with appropriate staff.

G) Services for Individuals with Severe Disabilities
We are concerned about the lack of available services for individuals with the most severe disabilities through these three waivers, particularly children and adults who are medically fragile or technology dependent but unable to qualify for the MFTD waiver due to technology type or age. These individuals often require skilled nursing care and 24-hour supervision. There are multiple solutions to ensure high needs individuals can access appropriate services through these waivers to avoid institutionalization. One may be to formalize a hospital level of care population within the waiver, using an appropriately enhanced rate based on an equally appropriate institutional comparison.

STATE RESPONSE: Thank you for your comments. We appreciate your suggestions.

CONTINUED FROM APPENDIX I-1:

The MA staff utilizes its Enterprise Data Warehouse (EDW) query capability to analyze the entire data set 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. Twice a year, the MA conducts analysis of all paid claims. Only claims that were not paid in accordance with set parameters are identified and extracted. Identified exceptions are printed out with 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 upon suspicion of fraud or inappropriate billing found in the report. Targeted reviews are not based on a specific percentage or representative sample. Targeted reviews provide a detailed review of services and claims during the timeframe in question of individual waiver services, utilization of waiver services by customer, and billing trends and patterns of providers. 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 Federal Financial Participation (FFP). The OA will contact the provider to collect 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. This review does not substantiate that the service was actually rendered. This review is a data query that looks at waiver eligibility, coding, and payment criteria. The state proposes to add the following sentence to the paragraph:

The MA also conducts a review of a statistically valid sample of payments (95% confidence level with a +/- 5% margin of error) to substantiate that the service was actually rendered. The paid claims selected in the sample are sent to the OA. The OA compares the paid claim with the clock-in/out data and the customer's Person-Centered Plan (PCP) to ensure the payment was made for services in the PCP and in the approved waiver.

Results of financial reviews are presented to OA personnel. The OA will advise the MA of corrective actions taken, including adjustments for all service claims identified by reviews that were not paid in accordance with parameters. FFP claims submitted to the MA are verified by cross-referencing multiple databases to ensure provider and customer are eligible at the time of service. Claims which do not meet the criteria needed for acceptance are reported back to the OA for audit and review. The FFP claims audit and review process includes over twenty (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. One of the audit reports lists claims that are potentially duplicate transactions. Each claim on the 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 and the MA to ensure 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.

For customers enrolled in a MCO, the MA's internal and external auditing procedures will ensure that payments are made 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 before paying claims.

CONTINUED FROM APPENDIX I-2-a

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 $1,500, three (3) bids are required. The lowest bidder is selected. If the lowest bidder cannot provide timely services, the next lowest bid may be selected. If three (3) bids cannot be obtained or a bid is the sole source for lack of available vendors, a formal justification as to why three (3) 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 $25,000 over a five (5) year period.

IL.0202.R07.03 effective 07/01/2025, or upon CMS approval.

Payments are subject to prior approval by the OA and MCO. For any item costing more than $5,000, two (2) bids are required. The lowest bidder is selected. If the lowest bidder cannot provide timely services, the next lowest bid may be selected. If two (2) bids cannot be obtained or a bid is the sole source for lack of available vendors, a formal justification as to why two (2) 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 the limits identified in 89 Ill. Adm. Code 686.605(c) and 686.705(d).

There is no difference in the method of rate determination for services self-direction from the methodology that is utilized when service is provider managed.

Amendment IL.0202.R07.01 - Effective 1/1/2024.
The State originally estimated cost per service for the waiver renewal without knowing what actual fee schedules would be effective during WY 1. Between the renewal and the amendment, the MA received actual fee schedules effective January 2024. Because we were already amending for homemaker, ADS and ADST increased costs, we amended cost per service for most services to the known fee schedules. Our original estimates in the renewal for WY 1 were generally higher than the since-established fee schedules, so we revised cost per service downward to reflect the actual fee schedules in this amendment.

The following services have rate increases effective January 1, 2024 in response to legislation passed by the Illinois General Assembly Medicaid Omnibus bill, SB1298:
Homemaker and Respite Homemaker services from $26.92 to $28.07. 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.
Adult Day Service and Respite Adult Day Service from $15.30 to $16.84

Adult Day Service Transportation and Respite Adult Day Service Transportation from $11.29 to $12.44

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 (DHS-DRS), the operating agency (OA)

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

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

Medicaid agency assessment of operating agency performance:

The Illinois Department of 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 responsibilities of both agencies. The interagency agreement is reviewed at least annually and updated as needed.

The OA is responsible for customer eligibility, Person-Centered Plan (PCP) development, Home Services Program (HSP) budgeting, enrolling waiver providers, assuring PCPs are implemented and that services and providers meet standards established in the approved waiver and governing rules. The MA maintains administrative oversight of the waiver. The MA enrolls providers in Medicaid, provides oversight, consultation, and monitoring of waiver operations, processes federal claims, and maintains an appeal process. 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 OA's 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 includes in their record reviews an evaluation of compliance with waiver performance measures and certain components of their contracts related to the waivers. The tools 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) assessment 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; PCPs 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 choices of services and providers are offered to the customer. PCPs are also reviewed for completeness, accuracy, and timeliness.

Health, Safety, and Welfare— customer records will be examined to determine that customers are aware of how and to whom to report abuse, neglect, and exploitation; and each customer with an individual worker 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 review 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 have occurred.

Remediation — the QIO and EQRO submit 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 3thirty (30), sixty (60), ninety (90), or greater than ninety (90) days. Remediation activities are to be consistent with the approved activities detailed within each performance measure. The MA, 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 are 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.:*

Case management services for the Persons with HIV or AIDS waiver are performed by contracted case management offices authorized by the operating agency, Department of Human Service, Division of Rehabilitation Services (DHS-DRS). There are 30 case management offices located statewide, that provide case management for fee-for-service (FFS) waiver customers. In areas of the state where contracted case management offices are not established, waiver customers receive case management services through HSP Rehabilitation Counselors employed through local OA offices. The OA Case Managers provide the following functions as defined in 89 Ill. Adm. Code Section 686.910:

1)Conducting the initial assessment of eligibility and information gathering;
2)Developing and monitoring the implementation of the Person Centered Plan;
3)Conducting a reassessment of level of care at least every 12 months for those cases in formal eligibility, three months for those cases that have been presumptively determined eligible for interim services (89 Ill. Adm. Code Section 684.80), or at such time when the customer's financial or physical condition or need for services changes;
4)Networking, coordination and brokering of services (i.e., referring and assisting the customer in obtaining other agencies' services);
5)Assisting the customer when personal assistance problems develop. Maintaining documentation these problems and the case management team's responses in the customer's case file;
6)Providing counseling and advocacy;
7)Acting as inter-agency liaison (e.g., with other DHS programs, vendors, hospitals);
8)Contacting customer a minimum of once per month by telephone with a face-to-face visit every other month
9)Maintaining and updating customer records; and
10)Monitoring the cost effectiveness of the PCP.

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 into HealthChoice Illinois. Customers enrolled in the Medicare Medicaid Alignment Initiative (MMAI) are not impacted by HealthChoice Illinois. For those waiver customers enrolled in a MCO, the MCOs will be responsible for care coordination, Person Centered Plan oversight, customer safeguards, prior authorization of waiver services, and quality assurance and quality improvement activities.

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 (FFS) record reviews.

MA oversight of the EQRO and QIO includes monitoring for timely receipt of contract deliverables, accurate content of contract deliverables, conduct weekly contract monitoring meetings, conduct a review of all contract deliverables and approve prior to dissemination, develop an annual work plan which establishes the scope and timeline activities, and participation in record reviews.

The OA is responsible for assessing the performance of the contracted case management offices. OA oversight of the contracted case management entities includes training and certification of new OA Case Managers, case management activities through the sample of customer records by the OA’s Quality Assurance unit, and ongoing review of WebCM reports for compliance and to assure at least monthly customer telephone contacts and every other month face-to-face contacts are conducted. The OA shares the results of their monitoring activities with the MA. The MA is notified immediately of serious concerns.

○ **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 (FFS) record reviews.

MA oversight of the EQRO and QIO includes monitoring for timely receipt of contract deliverables, accurate content of contract deliverables, conduct weekly contract monitoring meetings, conduct a review of all contract deliverables and approve prior to dissemination, develop an annual work plan which establishes the scope and timeline activities, and participation in record reviews.

The OA is responsible for assessing the performance of the contracted case management offices. OA oversight of the contracted case management entities includes training and certification of new OA Case Managers, case management activities through the sample of customer records by the OA's Quality Assurance unit, and ongoing review of WebCM reports for compliance and to assure at least monthly customer telephone contacts and every other month face-to-face contacts are conducted. The OA shares the results of their monitoring activities with the MA. The MA is notified immediately of serious concerns.

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 (PMs) 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 one hundred percent (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. The timeline for remediation is based on the requirements set by each Performance Measure, either immediate, 30, 60 or 90 day timeframes.

For the PMs 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 (MMIS), the MCOs' Information Systems, the MCOs' and OA's critical incident (CI) 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.

The OA's HSP Ashburn Unit monitors the contracted case management entities serving fee-for-service (FFS) customers by reviewing case management activity through review of the web-based virtual case management (WebCM) system. WebCM allows for review of waiver customer data and the ability to communicate real time with the OA Case Managers. All case information including demographics, eligibility, Person Centered Plan, and case notes are maintained in the system. WebCM allows contracted entities to enter case notes on assigned cases. The OA agency uses case notes to monitor case management activities. In addition, payment for case management is driven by documentation of required monthly telephone contacts and every other month face-to-face contacts. When case notes are not timely, the case manager is contacted. If the problem is not resolved on a local level, the HSP Ashburn Unit contacts the Director of the contracted case management entity for resolution. If satisfactory correction is not made, the OA initiates a focus review through the quality assurance unit.

The OA oversight and monitoring of the OA Case Managers includes:
1) Training and certification of provisional (new) OA Case Managers;
2) Reviewing OA Case Managers activities through the sample of customer records by the OA's Quality Assurance unit; and
3) Ongoing OA review of WebCM reports for compliance and to assure at least monthly customer telephone contacts and every other month face-to-face contacts are conducted.

The OA shares the results of their monitoring activities with the MA. The MA is notified immediately of serious concerns. OA quality improvement reports of collected data and remediation are discussed at quarterly Waiver Management Meetings.

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.

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

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

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

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

Responsible Party for data collection/generation*(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:

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: Total number of QMC meetings where MCO quality performance data was reviewed.

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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**
	☐ **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:
(Those attending ADS Only)

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 OA and MCO person centered plans reviewed.

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

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*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 (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 a 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. 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 thirty (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 thirty (30) days.

A3: The MA will require completion of overdue reports. The MCO will submit a plan of correction within thirty (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 submit 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 the 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**

Responsible Party*(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:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☒	**HIV/AIDS**	0		☒
	☐	**Medically Fragile**			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	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 HIV or AIDS with severe functional limitations, which are expected to last at least 12 months or for the duration of life.

Other Criteria include:

1. Be a citizen of the United States, or be an individual who is living permanently in the United States after having been legally admitted;
2. Be a resident of the State of Illinois.
3. Be Medicaid eligible.
4. Be enrolled in only one waiver, the waiver that most appropriately meets his or her needs.
5. Be an individual with a disability who is in need of long-term care, as determined by the DON score completed as a result of a prescreening (89 Ill. Adm. Code 679) or application for HSP services. In order to be determined to have met this criteria, the individual must receive a DON score of at least 15 points on part A, which includes, if applicable, the 10 points from the Mini-Mental Examination, with a total DON score of at least 29 points; and
6. Ability to be maintained in the home at a service cost that does not exceed 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:

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 and described in a 1990 journal article (i.e., 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 Illinois 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 (DON) scores and associated Service Cost Maximums (SCM) effective 3/1/2023. SCMs may be updated in the future, based on increases in provider rates or other factors that impact the cost of waiver services.

DON Range Service Cost Maximum
29-32 $2,776
33-40 $3,067
41-49 $3,423
50-59 $4,097
60-69 $4,812
70-79 $5,201
80-100 $5,591

Amendment IL.0202.R07.01, the SCMs below are effective 01/01/2024.

DON Range	Service Cost Maximum
29-32	$2,785
33-40	$3,077
41-49	$3,434
50-59	$4,110
60-69	$4,827
70-79	$5,217
80-100	$5,608

Amendment IL.0202.R07.02, the SCMs below are effective 08/01/2024.

DON Range	Service Cost Maximum
29-32	$2,861
33-40	$3,161
41-49	$3,528
50-59	$4,223
60-69	$4,959
70-79	$5,360
80-100	$5,761

Amendment IL.0202.R07.03, the SCMs below are effective 01/01/2025.

DON Range	Service Cost Maximum
29-32	$2,945
33-40	$3,254
41-49	$3,632
50-59	$4,347
60-69	$5,104
70-79	$5,517
80-100	$5,930

Amendment IL.0202.R07.04, effective 07/01/2025, or upon CMS approval.

DON Range	Service Cost Maximum
29-32	$3,021
33-40	$3,338
41-49	$3,726
50-59	$4,459
60-69	$5,236
70-79	$5,659
80-100	$6,083

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) Eligibility is determined by meeting the minimum State established nursing facility 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 89 IL. Adm. Code, Part 682, DHS-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 Service Cost Maximum (SCM) for an individual 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. Additional services may be authorized in any amount to meet the customer needs within the parameters detailed above. Such an increase in services shall not last more than three months.

If a customer does not meet eligibility requirements as outlined in the 89 Illinois Administrative Code, Section 682, the OA sends the customers Service Notice that informs the individual why he or she is not eligible. The notice also includes a statement that if the person does not agree with this planned action, that individual can request a hearing. 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 assessment (DON), the HSP Rehabilitation Counselors conduct a more comprehensive needs assessment that addresses multiple areas of needs, including non-waiver services. The OA Case Manager completes a narrative statement about the customer that accompanies this assessment. HSP offices utilize various community resources to assist the waiver customers to access services when needed that are not covered under the waiver.

The Service Cost Maximums (SCMs) for the HIV/AIDS waiver were established to address the need for therapy and other HIV/AIDS supportive services. If a customer has complex medical needs that cannot be served within the allowable SCM, the HSP Rehabilitation Counselor may request an exceptional care rate (ECR). The ECR is determined by the MA and based on analysis of minimum data set (MDS) data of persons with similar medical needs served in nursing facilities. If the established 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. See Appendix C-4 for more information on ECR

Effective 7/1/2025, or upon CMS approval:
The exceptional care rate (ECR) is established by the MA by multiplying the daily rate of 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. If the established 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	1263
Year 2	1263
Year 3	

Waiver Year	Unduplicated Number of Participants
	1263
Year 4	1263
Year 5	1263

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 HSP Rehabilitation Counselors or OA Case Managers 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 HSP Rehabilitation Counselors r OA Case Managers 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)

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

○ **Section 1634 State**

○ **SSI Criteria State**

◉ **209(b) State**

2. Miller Trust State.

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

◉ **No**

○ **Yes**

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

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

☐ **Low income families with children as provided in §1931 of the Act**

☐ **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 §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §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 §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 §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 state proposes to add:
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.

3) Caretaker relatives specified at 42 CFR 435.110.

4) Children specified at 42 CFR 435.118.

5) Pregnant women specified at 42 CFR 435.116.

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, 2019 (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 §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 §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §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 periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (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 periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

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 periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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 §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

◉ **The following standard included under the state plan**

(*select one*):

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

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The special income level for institutionalized persons**

(*select one*):

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

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

  Specify dollar amount:
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ◉ **Other standard included under the state plan**

  Specify:

  The maintenance allowance for waiver customers equals the maximum income a customer can have and be eligible under 435.217.
- ○ **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 435.726:

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 periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §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 §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 participants 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:

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 five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §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:

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.

OA Case Managers that are performing level of care evaluations must be:
1) A Registered Nurse, with a current license and a bachelor's degree in nursing, social work, social sciences, or counseling or one year of case management experience; or

2) A social worker with a bachelor's degree in either social work, social sciences, or counseling. A Bachelor of Social Work or a Master of Social Work degree from a school accredited by any organization nationally recognized for the accreditation of schools of social work is preferred; or

3) A human services professional with a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling) with a minimum of one year of case management experience.

In addition, it is mandatory that the case manager has:

1) Broad knowledge of community resources and networking, case management, and home care; and

2) Experience in working with racial and ethnic minorities, as well as one or more of the following:
- domestic abuse;
- the lesbian, gay, bisexual, transgender, queer (LGBTQ+) community;
- persons living with HIV/AIDS; and
- persons with substance use disorders.

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.

In order to be eligible for waiver services, the customer must be evaluated with the Illinois Determination of Need (DON) assessment tool and receive at least 15 points on functional impairment and a total of 29 points. This assessment includes a mini-mental state examination (MMSE) and functional status section. The functional status section assesses both activities of daily living (ADL) and instrumental activities of daily living (IADL). 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. Case managers receive training and guidelines for scoring each area consistently. The DON is the same criteria used to assess for nursing facility eligibility. The final score is calculated by adding the results of the MMSE, the level of impairment and the unmet need. State rules regarding prescreening are found in 89 Ill. Adm. Code, Part 681. State rules pertaining to the DON are found in 89 Ill. Adm. Code, Part 679.

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:

OA Case Managers and HSP Rehabilitation Counselors conduct the level of care evaluations and reevaluations utilizing the Determination of Need assessment tool and the same processes as described above.

For customers enrolled in an MCO, the reevaluations are conducted by OA Case Managers or HSP Rehabilitation Counselors.

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 has the ability to run monthly reports through a Virtual Case Management computer system, called WebCM, that does two things:

1) Creates a "To Do" list that gives case managers a 30-day advance notice of upcoming reassessments and 2) identifies OA Case Managers and 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 MA.

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

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

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 by the HSP Ashburn Unit. 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 for five years. 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:
Operating Agency: Eligibility Reports

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

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

Data Aggregation and Analysis:

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

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

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):
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 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. 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 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 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. 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 sixty (60) days.

B2: 1. LOC is completed 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 sixty (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 the OA Case Manager or the 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).

OA Case Managers and HSP Rehabilitation Counselors inform applicants of the feasible alternatives available under the waiver and outside of the waiver at the time they apply for services and during each subsequent reassessment. The OA Application and Redetermination of Eligibility document and the Appeal Fact Sheet are given at the initial assessment and at subsequent reassessments.

The Application and Redetermination of Eligibility form contains information regarding the OA Home Services Program (HSP), eligibility and services. The Appeals Fact Sheet contains information regarding the customer's right to appeal any case decision. The information is reviewed and explained at initial assessment and during each reassessment. The design of the Application and Redetermination of Eligibility form requires applicants to initial each section of the document to verify 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 reassessment.

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 Person Centered Plan will assist them in remaining there.

The Mini Mental State Examination (MMSE) is a cognitive component of the Determination of Need (DON) assessment tool and is administered during each assessment and reassessment to assist in determining whether or not the customer can safely direct his or her own care. If so determined, the customer may choose among service providers, and may direct and train the caregiver. If it is determined that the customer does not have this capacity, and no responsible family member or guardian is available, then an agency employed provider, such as homemaker or home health caregiver, will be utilized.

For those served by the OA, customer preference and choice is also verified by the customer's signature on the service plan. By signing, the customer acknowledges that they have been given a choice between home care and institutional/nursing facility care and waiver services.

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 HSP Ashburn Unit or local HSP office for two (2) years and then transferred to the State Records Center in Springfield, Illinois, for five (5) years, after which at which time they 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 a MCO, the MCO will maintain the forms for a minimum of ten (10) 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 OA case managers serve as access points and are integrated into the communities. In some areas, the case managers interact on a daily basis, with a wide variety of individuals with varying backgrounds, cultures, and languages. Written materials are available in English and Spanish. The HSP Rehabilitation Counselors and the OA Case Managers have resources available to communicate effectively with persons of limited English proficiency in their community, including bilingual staff as needed, interpreters, and translated forms. Interpreter services are provided at no cost to customers. The OA has a contract with Propio, an online and telephonic language service to provide language translation services. Over 200 languages may be translated through this service. In instances where Propio cannot interpret a language, OA staff seek family members or friends who may provide this service, with the approval of the customer.

For customers enrolled in a 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	**Intermittent Nursing**		
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**		

Service Type	Service		
Other Service	Personal Emergency Response System		
Other Service	Specialized Medical Equipment and Supplies		

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:**

Service Definition *(Scope):*

Adult Day Service (ADS) is the direct care and supervision of adults aged 60 or over, in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting. Service are furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the customer's person-centered plan of care, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant.

Required service components include:
1. Assessment of the customer's strengths and needs and development of a PCP specific to ADS that is integrated into the overall PCP and provides direction specific to the delivery of the ADS service and all service components to be provided or arranged by the service provider. The ADS section of the customer's PCP is developed and evaluated with the customer and his or her family/individual representative in coordination with the adult day service team and developed so that it complements the customer's PCP. The customer is provided with the opportunity to lead development of the ADS PCP and shall have an active role in its development. The planning process addresses the personal goals of the customer, his/her strengths and needs, and any risks identified through the comprehensive assessment process.

2. 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.

3. 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.

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

5. Activity opportunities shall be available whenever the service providers facility is in operation and customers are in attendance.

6. A monthly calendar of activities of daily living shall be prepared and posted in a visible place along with notification/discussion of alternative options to daily activities as outlined on the calendar.

7. Assistance with or supervision of activities of daily living (e.g., walking, eating, toileting, and personal care) as needed.

8. 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.

9. A meal at mid-day 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 client's physician.

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

11. Provision of emergency care as appropriate in accordance with established adult day service providers' policies and OA rules.
Services are provided according to the person-centered plan of care within the service cost maximum.

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

A maximum of two (2) one-way trips per day will be provided.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Service

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Adult Day Service

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Ill. Admin. Code Section 686.100

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Every two (2) years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

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:**

Service Definition *(Scope):*

Homemaker services consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. The purpose of providing in-home (homemaker) services is to maintain, strengthen, and safeguard functioning of customer in their own homes in accordance with the authorized Person-Centered Plan of Care (PCP). Homecare aides shall meet such standards of education and training as are established by the State for the provision of these activities.

Specific components of in-home service (homemaker) shall include the following:
1. Teaching/performing of meal planning and preparation; routine housekeeping skills/tasks (e.g. making and changing beds, dusting, washing dishes, vacuuming, cleaning and waxing floors, keeping the kitchen and bathroom clean and laundering the customer's linens and clothing); shopping skills/tasks; and home maintenance and minor repairs.

2. Assisting with self-administered medication which shall be limited to:
• Reminding the customer to take his/her medications;
• Reading instructions for utilization;
• Uncapping medication containers; and,
• Providing the proper liquid and utensil with which to take medications.

3. 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 in-home service (homemaker) supervisor.

4. 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).

5. Observing customers' functioning and reporting to the supervisor.

6. 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.

7. Escort to medical facilities, errands, shopping and individual business as specified in the PCP. In-home (homemaker) services may include transportation to medical facilities, or for essential errands/shopping, or for essential customer business with or on behalf of the customer as specified in the PCP.

This service will be provided if the consumer cannot or does not want to manage an Individual Provider (IP). The amount, duration, and scope of services is based on the DON score and service cost maximum (SCM) level as approved by the OA.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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 Ill. Admin. Code Section 686.200

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and every two (2) years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

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:**

Service Definition *(Scope):*

An Individual Provider (IP) provides 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. Such assistance may include assistance in performing ADLs (bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities, e.g. personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication and money management). Such assistance also may include the supervision of participants as provided in the Person-Centered Plan. Health-related services may be provided, including skilled care or nursing care and medication administration. The customer as the employer trains the IP to provide the health-related services required.

Individual Providers (IP) are non-agency based personnel. An IP can be an independent worker, CNA, LPN, or RN. The IP assists with eating, bathing, personal hygiene, and other activities of daily living (ADLs) in the home and at work (if applicable). These services may include assistance with preparation of meals but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include housekeeping chores, such as bed making, dusting, vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the customer rather than the customer’s family. Personal care will only be provided when it has been determined by the HSP Rehabilitation Counselor, OA Case Manager or MCO Care Coordinator that the customer has the ability to supervise the IP. The IP is the employee of the customer. The state acts as the fiscal agent for the customer.

IPs are hired independently by the customer and excluded from the Healthcare Worker Background Check Act (the Act) (225 ILCS 46). Other providers exempt from the Act include independently hired licensed providers including RNs, LPNs, and therapists. The Illinois Department of Financial and Professional Regulation (IDFPR) in accordance with their licensure requirements covers licensed providers. Independent CNAs are covered through the Health Care Worker Registry (HCWR).

The Illinois State Police (ISP) maintains a database of criminal convictions in Illinois. Certain agencies providing direct services to individuals are required by law to request criminal conviction history information as a condition of employment. The State offers customers the option to conduct the background checks without cost when hiring the IP. Homemaker services are always provided through an agency. Homemaker agencies are subject to the Act and therefore must conduct criminal background checks on all homemakers. The Act lists the convictions that disqualify them from service agency employment.

Customers have the option to conduct HealthCare Worker Background Checks (HCWBC) on an IP, at no cost to the customer. The OA and MCO provides information to the customers on how to request the HCWBC. The results are returned directly to the customer. The Illinois Department of Public Health verifies that home health agencies comply with the HCWBC Act during licensure reviews. DRS verifies that homemakers and adult day service agency staff have HCWBC when they conduct compliance reviews. The MA verifies compliance during onsite monitoring reviews for home health, homemaker, and adult day service agencies.

IPs requirements are checked annually at the time of redeterminations to ensure they continue to meet waiver requirements. All other providers are agency providers, all of whom have some sort of licensing requirement. In addition, the OA and the IDoA conduct reviews every two (2) ears of several types of providers to check payment records at every level from workers turning time in to submitting bills to the OA. In addition, all other criteria for being an approved provider are checked, such as credentials of the director, training records, and physical location.

The amount, duration, and scope of services are based on the DON assessment conducted by the HSP Counselor or OA Case Manager and the SCM determined by the DON score. IP services cannot be duplicative of services offered under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

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**

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 Ill. Admin. Code Section 686.10

In order to be employed by a customer as a 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 (2) 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 (2) 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 IP under the HSP, some of which also require the customer's signature. The individual shall provide services to the customer in accordance with the Customer's PCP and he/she shall comply with the Program's policies and procedures related to the Electronic Visit Verification (EVV) system and the HSP 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, OA Case Manager and MCO Care Coordinator. DRS and HFS also verify during monitoring.

Frequency of Verification:

At time of initial employment and during annual evaluations conducted by the customer.

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:**

Service Definition *(Scope):*

Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the customer. Respite services can be provided by IPs, homemakers, RN, LPN, ADS, 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. Federal matching funds will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. It may be provided in the following places: customer's home; or in an ADS setting.

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

Respite is limited to 240 hours per year. The payment system has edits on which services may be provided through the Respite service, tracks the number of Respite hours provided during the calendar year, and will not allow more than 240 hours to be billed.

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

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

☒ **Provider managed**

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
Individual	Individual Provider
Individual	RN
Individual	Home Health Aide
Agency	Adult Day Service
Individual	LPN
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Homemaker

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Admin. Code Section 686.200

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Every two (2) years.

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 Ill. Admin. Code Section 686.10

Verification of Provider Qualifications

Entity Responsible for Verification:

The customer verifies initially and OA and MA verify during monitoring.

Frequency of Verification:

Prior to being hired.

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):*

210 ILCS 65

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: 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

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: 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 Ill. Admin. Code Section 686.100

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Enrollment and every two (2) years.

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):*

120 ILCS 65

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 annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55

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 annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

Service Definition *(Scope):*

Home Health Aide (HHA) in the waiver is an extended State Plan version of the "Home Health Aide" service in the State Plan and on the HFS Fee Schedule for Home Health Nursing Agencies. Services provided through the State Plan are provided on a short-term or intermittent basis. These services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the 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 sixty (60) days following discharge from a hospital or long-term care facility do not require prior approval when services are initiated within fourteen (14) days of discharge. HHAs in the State Plan are paid per visit; rather than hourly. Visits are limited to two (2) hours or less.

HHA services, under the waiver are paid hourly and may be provided when the individual does not meet the prior approval requirements for the State Plan services. The waiver services are in addition to any Medicaid State Plan HHA services for which the customer may qualify. HHA services through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

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

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

All waiver clinical services require a prescription from a physician. The amount, duration and scope of services is based on the DON assessment conducted by the HSP Rehabilitation Counselor or the OA Case Manager and SCM for the DON.

This waiver service is only provided to individuals ages 21 and over. All medically necessary home health aide 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**

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	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 47/3-206, Curriculum for Training Nurse Assistants and Aides

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At the time of enrollment and annually

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

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At the time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

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:**

Service Definition *(Scope):*

Intermittent nursing in the waiver is an extended State Plan version of the Home Health Nursing services in the State Plan and the "Skilled Nursing" service on the HFS Fee Schedule for Home Health Nursing Agencies. Services provided through the State Plan are provided on a short-term or intermittent basis. These services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the 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 sixty (60) days following discharge from a hospital or long-term care facility do not require prior approval when services are initiated within fourteen (14) days of discharge. Intermittent or "skilled" nurses are paid per visit; rather than hourly. Visits are limited to two (2) hours or less.

Intermittent Nursing Services, under the waiver, may be provided when the individual does not meet the prior approval requirements for the State Plan services. The Intermittent nursing in the waiver is an extended State Plan version of the Home Health Nursing services in the State Plan and the "Skilled Nursing" service on the HFS Fee Schedule for Home Health Nursing Agencies. Services provided through the State Plan are provided on a short-term or intermittent basis. These services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the 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 sixty (60) days following discharge from a hospital or long-term care facility do not require prior approval when services are initiated within fourteen (14) days of discharge. Intermittent or "skilled" nurses are paid per visit; rather than hourly. Visits are limited to two (2) hours or less.

Intermittent Nursing Services, under the waiver, may be provided when the individual does not meet the prior approval requirements for the State Plan services. The waiver services are in addition to any Medicaid State Plan nursing services for which the customer may qualify. Nursing through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Nursing services that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or a licensed practical nurse, licensed to practice in the state. Specific tasks that may be performed are outlined below:

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

Registered Nurses: May provide and coordinate care, educate customers and the public about various health conditions, and provide advice and emotional support to customers and their family members. Registered Nurses duties may 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 customers and their families how to manage their illnesses or injuries, as well as explaining at home treatment options.

The amount, duration, and scope of services is based on the DON score and service cost maximum level as approved by the OA.

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 customers PCP.

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**

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	Licensed Practical Nurse

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Intermittent Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

210 ILCS 65

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Intermittent Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

225 ILCS 65, 225 ILCS 65/55-10, 225 ILCS 55.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Intermittent Nursing

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

210 ILCS 65

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

Service Definition *(Scope):*

Occupational Therapy (OT) in the waiver is an extended State Plan version of the OT service in the State Plan. Services provided through the State Plan are provided on a short-term or intermittent basis. Under the State Plan, adults are allowed twenty (20) therapy visits, per year. Prior approval is required. For children there are no limits. State Plan services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. These 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. Services may be provided under the waiver when the individual does not meet eligibility requirements for the State Plan services.

Services are provided by a licensed occupational therapist that meets Illinois licensure standards. Waiver services are in addition to any Medicaid State Plan services for which the customer may qualify. OT through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Specific tasks may include: instructing persons on techniques and equipment that can make daily living and working easier. The OT treats persons with injuries, illnesses, or disabilities, through the therapeutic use of everyday activities. They help develop, recover, and improve the skills needed for daily living. Duties include but are not limited to evaluating the person's condition and needs, establishing a treatment plan, determining the types of activities and specific goals to be reached, demonstrating exercises that can help relieve pain, evaluating a home or workplace, identifying how it can be better suited to the person's health needs, educating the family about how to accommodate and care for the person, recommending special equipment, such as wheelchairs and eating aids, instructing on how to use the equipment, assessing and recording activities and progress, and reporting information to physicians and other healthcare providers.

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 PCP. The amount, duration, and scope of services is based on the DON score and SCM as approved by the OA.

This waiver service is only provided to individuals ages 21 and over. 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**

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

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: 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

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

Service Definition *(Scope):*

Physical Therapy (PT) in the waiver is an extended State Plan version of the PT service in the State Plan. Services provided through the State Plan are provided on a short-term or intermittent basis. Under the State Plan, adults are allowed twenty (20) therapy visits, per year. Prior approval is required. For children there are no limits. State Plan services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. These 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. Services may be provided under the waiver when the individual does not meet eligibility requirements for the State Plan services.

Services are provided by a physical therapist that meets Illinois licensure standards. Services are in addition to any Medicaid State Plan services for which the customer may qualify. Physical therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Physical Therapists (PT) may perform the following tasks:
-Provide care to people of all ages who have functional problems resulting from injuries or medical conditions.

-Help people improve their movement and manage their pain, often playing an important role in the rehabilitation and treatment of patients with chronic conditions or injuries.

-Diagnose person's dysfunctional movements and design plans to address, outlining goals and planned treatment, evaluating progress, modifying a treatment plan, and educating patients and their families about what to expect during recovery from injury and illness.
-Use exercises, stretching maneuvers, hands-on therapy, and equipment to ease pain and to help increase ability to move.

-Work as part of a healthcare team, overseeing the work of PT assistants and aides, consulting with doctors and other specialists.

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 PCP.

The amount, duration, and scope of services is based on the DON score and SCM as approved by the OA.

This waiver service is only provided to individuals ages 21 and over. All medically necessary physical therapy service 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**

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):*

225 ILCS 55

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: 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

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

Service Definition *(Scope):*

Speech Therapy (ST) in the waiver is an extended State Plan version of the ST service in the State Plan. Services provided through the State Plan are provided on a short-term or intermittent basis. Under the State Plan, adults are allowed twenty (20) therapy visits, per year. Prior approval is required. For children there are no limits. State Plan services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. These 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. Services may be provided under the waiver when the individual does not meet eligibility requirements for the State Plan services.

Services are provided by a speech therapist that meets Illinois licensure standards. Services are in addition to any Medicaid State Plan services for which the customer may qualify. Speech therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Speech Therapists (ST), also referred to as Speech-Language Pathologists may perform the following tasks:
-Diagnose and treat a variety of speech, language, and swallowing disorders.

-Evaluate levels of speech or language difficulty, determining the extent of communication problems by having the person complete basic reading and vocalizing tasks or by giving standardized tests.

-Identify treatment options, creating and carrying out an individualized treatment plan.

-Teach how to make sounds and improve voices, teaching alternative communication methods, such as sign language, to

those with little or no speech capability.

-Strengthen the muscles used to swallow, while counseling patients and families on how to cope with communication disorders.

-Assist with increasing the ability to read and write correctly, developing.

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 PCP.

The amount, duration, and scope of services is based on the DON score and SCM as approved by the OA.

This waiver service is only provided to individuals ages 21 and over. 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**

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	Speech Therapist
Agency	Home Health Agency

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):*

225 ILCS 110

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: 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

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Those physical adaptations to the home, required by the individual's Person-Centered plan of care, 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. Generators are not included.

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, vehicle 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.

All environmental modifications providers must submit a completed 1413A-Waiver Program Provider Agreement for Participation in the Illinois Medical Assistance Program form; submit a completed W-9 Request for Taxpayer Identification Number and Certificate; carry a minimum of $500,000 in liability insurance, and provide DHS-DRS with a copy of the Certificate of Insurance verifying current coverage; maintain current and appropriate contractor licenses, as applicable; perform all modifications so that they meet the standards established by the Environmental Barriers Act, the Illinois Accessibility Code [71 ILCS 400] and local zoning ordinances and codes; and obtain proper building permits as required by local municipalities.

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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 Ill. Admin. Code 686.600

All Environmental Modification providers meet the approval of the customer and counselor; submit a completed 1413 A – Waiver Program Provider Agreement for Participation in the Illinois Medical Assistance Program form; submit a completed W-9 Request for Taxpayer Identification Number and Certificate; carry a minimum of $500,000 in liability insurance, and provide DHS-DRS with a copy of the Certificate of Insurance verifying current coverage; provide proof of appropriate current contractor licenses, as applicable; perform all modifications so that they meet the standards established by the Environmental Barriers Act, the Illinois Accessibility Code [71 ILCS 400] and local zoning ordinances and codes; and obtain proper building permits as required by local municipalities.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Prior to project initiation

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:

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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 PCP and will not duplicate those services provided by personal care services or homemaker provider. Meals provided shall not constitute a full nutrition regimen (customers are not receiving 3-meals per 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 PCP 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 seven (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 OA 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**

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 Ill. Admin. Code 686.500

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

The OA obtains a copy of the HDM agency's Public Health certificate on an annual basis to verify that the provide meets state and local health codes.

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:**

Service Definition *(Scope):*

The waiver provides in-home shift nursing to adults (age 21 and over). In-home shift nursing is not covered in the Illinois State plan. However, it is covered for individuals under 21 years of age, through EPSDT.

In-home shift nursing is different than intermittent nursing because customers require hourly shift nursing rather than an intermittent visit, to perform a specific task.

Services are provided by RNs and LPNs that meets Illinois licensure standards for nursing services. See below for more detail.

RNs may provide and coordinate care, educate the customer and the public about various health conditions, and provide advice and emotional support. RNs 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. Some RNs supervise LPNs, nursing aides, orderlies, attendants, and home health and personal care aides. Nursing through the waiver, focuses on long term habilitative needs rather than short-term acute restorative needs.

LPNs provide basic medical care, under the direction of RNs and doctors. LPN's duties may include but are not limited to administering basic nursing care, monitoring health by checking blood pressure, changing bandages, inserting catheters, providing basic comfort, including bathing and dressing, as well as discussing health care with the customers and families, addressing concerns, while keeping adequate records regarding health, and reporting pertinent information to registered nurses and physicians. The duties of an LPN may vary, depending on work setting and state. Nursing through the waiver, focuses on long term habilitative needs rather than short-term acute restorative needs.

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 customers PCP. The amount, duration, and scope of services is based on the DON score and SCM as approved by the OA.

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	LPN
Agency	Home Health Agency
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:

Individual

Provider Type:

LPN

Provider Qualifications

License *(specify):*

225 ILCS 65/55/10

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: 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):*

210 ILCS 55/1

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: 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 65/60, the Professions and Occupations Nurse Practice Act

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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:

Service Definition *(Scope):*

Personal Emergency Response System (PERS) is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person'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 individuals 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.

The amount, duration, and scope of services is based on the DON score and SCM level as approved by the OA.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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 Ill. Admin. Code Section 686.300

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

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:**

Service Definition *(Scope):*

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals 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 individual. All items shall meet applicable standards of manufacture, design and installation.

The amount, duration, and scope of services is based on the DON score and SCM level as approved by the OA.

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

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

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

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

☒ **Provider managed**

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	Medical Suppliers
Agency	Pharmacies

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Medical Suppliers

Provider Qualifications

License *(specify):*

225 ILCS 51

Certificate *(specify):*

N/A

Other Standard *(specify):*

68 Ill. Admin. Code Part 1253

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Providers must maintain at least $500,000 in liability insurance. A copy of the insurance certificate is obtained by HSP counselor or OA Case Manager and maintained in customer's case file. Within 30 calendar days of customer's receipt of equipment, the case manager/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.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Pharmacies

Provider Qualifications

License *(specify):*

225 ILCS 85

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Providers must maintain at least $500,000 in liability insurance. A copy of the insurance certificate is obtained by HPS counselor or case manager and maintained in customer's case file. Within 30 calendar days of customer's receipt of equipment, the case manager/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.

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 §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §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.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The Illinois Department of Human Services (DHS) operates the Home Service Program (HSP) HIV or AIDS Waiver by authorizing case management entities throughout the State to directly oversee the care under this 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.

OA Case Managers that are performing level of care evaluations must be:
1) A Registered Nurse, with a current license and a bachelor's degree in nursing, social work, social sciences, or counseling or one year of case management experience; or

2) A social worker with a bachelor's degree in either social work, social sciences, or counseling. A Bachelor of Social Work or a Master of Social Work degree from a school accredited by any organization nationally recognized for the accreditation of schools of social work is preferred; or

3) A human services professional with a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling) with a minimum of one year of case management experience.

In addition, it is mandatory that the case manager has:

1) Broad knowledge of community resources and networking, case management, and home care; and

2) Experience in working with racial and ethnic minorities, as well as one or more of the following:
- Domestic abuse;
- The lesbian, gay, bisexual, transgender, queer (LGBTQ+) community;
- Persons living with HIV/AIDS; and
- Persons with substance use disorders.

All OA Case Managers are required to attend an initial training by the OA. The OA Program Manager assures that all new OA Case Managers meet the requirements as outlined under 89 Ill. Admin. Code 686. There are two levels of case management: provisional case manager and case manager. A provisional case manager is one who has not satisfactorily completed a certification examination. Provisional case managers are required to submit all developed plans to their agency supervisor for approval. The agency supervisor must be a certified Case Manager. All provisional Case Managers will work toward meeting Case Manager standards within six months after receiving the HSP Case Manager training.

HSP Rehabilitation Counselors may also conduct case management functions when OA Case Managers are not available.

For customers enrolled in an 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 must meet the criteria to re-enroll 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.

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 MA initiated a provider enrollment system in Fiscal Year 2016 in response to requirements of the Affordable Care Act (ACA). The Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system is a web-based system designed to improve provider access and to ensure customers receive timely and high-quality Medicaid services, including services provided to Medicaid waiver customers. Providers must be enrolled in the IMPACT system prior to being reimbursed for services. Background checks are completed on each provider during the enrollment process. 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 ISP for direct service staff hired by specified health care employers in Illinois. The agencies include those providing home health, homemaker, or ADS. 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 IDFPR or the IDPH under another law of the State, including Registered Professional Nurses (RN), Licensed Practical Nurses (LPN), or licensed therapists.

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

The IDPH maintains the HCWR. Home health agencies must conduct screenings on all CNAs prior to providing care. Registry checks are maintained in the employee's file. IDPH verifies compliance for home health agencies during licensure reviews. The 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 HCWR see: http://www.idph.state.il.us/nar/home.htm.

Homemaker agencies and IPs 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 HSP Rehabilitation Counselors offer 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 disqualify 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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *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 legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure 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 services 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. The number of hours an LRI is authorized to work will be the lessor of the hours identified as extraordinary care or 40 hours per week. An additional IP or homemaker agency must be employed to work the remaining hours in the person-centered plan. Customers with a 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 like all other Individual Providers but must not exceed the total allowable hours assigned to extraordinary care tasks or 40 hours in a week, whichever is less. 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. 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 a 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.

☒ **Self-directed**

☒ **Agency-operated**

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 specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls 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.*

The need for an LRI must be reflected in the customer's PCP as addressing specific needs and there must be documentation in the customer record that demonstrates there are no other viable service/provider alternatives presented at the time-of-service authorization. The PCP must identify which tasks are considered extraordinary care. Services that may be provided by LRIs employed as IPs working as a certified nursing assistant, licensed practical nurse, registered nurse, occupational therapist, physical therapist, or speech therapist as prescribed.

Customers who are able to hire a LRI to provide extraordinary care services may also need to hire an additional IP to provide the other services identified on the service plan. The LRI must meet all IP 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. LRIs with history of abuse, neglect, or exploitation are not eligible, nor are those customers or LRIs who have committed Medicaid fraud or fraud against HSP.

Limits apply to services provided by the legally responsible person, relative, and legal guardian. The number of hours an LRI is authorized to work will be the lesser of the hours identified for personal care services when they meet the definition of extraordinary care or 40 hours per week. An additional IP or homemaker agency must be employed to work the remaining hours in the person-centered plan.

Payment will not be made to a LRI or other IP while the customer is hospitalized. If there is a hospital claim on the same day as a LRI's or other IP's claim, the claim will be reported to the HSP Fraud Unit. All LRI provided services will be closely monitored for fraud and abuse. LRIs must be qualified to meet all Federal and State regulatory guidelines and must be hired by the customer as an IP. LRIs are not permitted to work for the customer through a homemaker or maintenance home health agency. Timesheets for a LRI are signed by the customer to verify that the services were rendered. If the customer is not able to verify time worked, 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 LRI 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 who hire a LRI must consent to additional in-home visit wellness checks. Unannounced, in-person wellness checks will be conducted in the customer home twice a year by the HSP Rehabilitation Counselor, OA Case Manager, or MCO Care Coordinator. These visits are in addition to the annual home visit by HSP. Quarterly in home visits by the MCO Care Coordinator will continue, according to managed care contract. Two (2) of these visits will be unannounced. 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.

Customers have the authority to hire and fire IPs and to direct provision of IP services. IPs are reimbursed on a twice monthly basis 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 IP as detailed on the timesheet and therefore authorizes payment to the IP for the services provided.

The customer completes an annual IP evaluation where the customer officially evaluates the IP's work performance, and verifies that services were provided to the customer, which may include changing IPs or transitioning to a provider from the next highest level of care (i.e., utilizing an agency-based provider). For minor children who hire a LRI, an authorized representative must be identified to complete the annual IP evaluation.

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 waiver are 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 IDFPR. The State Medicaid Agency (MA) enrolls all willing and qualified providers that are chosen for waiver services through the IMPACT system.

Many 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 OA uses any homemaker agency that meets enrollment requirements, and if enrolled, must provide services within the scope of the 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.

ADS 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 IDoA.

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 County Care, 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

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 ninety (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 an IP.

Personal Emergency Response System: MCOs must meet 89 Ill. Admin. Code Section 240.235 with at least one provider serving each county within a contracting area.

All provider qualifications and requirements are found 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 FFS Medical Program. MCOs may establish quality standards in addition to those State and Federal requirements and contract only with providers that meet such standards. Such standards must be approved by the MA, in writing, and MCOs may only terminate the contract of a provider based on failure to meet such standards if two criteria are met a) such standards have been in effect for at minimum one (1) year, and b) providers are informed at the time such standards come into effect.

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**
	☐ **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**
	☒ **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 Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
C5: # and % of HSP RCs, OA CMs, and MCO CCs who meet training requirements in accordance with state requirements and the approved waiver prior to providing waiver services. N: # of HSP RCs OA CMs, 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 HSP RCs, OA CMs, and MCO CCs.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:
HSP Training Reports, OA CMs 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: # and % of HSP RCs, OA CMs, and MCO CCs who cont. to meet training req. in accordance with state reqs and the approved waiver prior to continuing to provide waiver services. N: # of HSP RCs, OA CMs, and MCO CCs who cont. to meet training req. in accordance with state reqs and the approved waiver prior to continuing to provide waiver services. D: Total # of HSP RCs, OA CMs, 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:
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**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

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 IDPH's HCWR 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 monitor network capacity to ensure an adequate network.

For training, the MA will request reports from the OA and the MCOs to verify that HSP Rehabilitation Counselors 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. 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 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 thirty (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 thirty (30) days.

C3: Provider will be notified by the OA of lacking documentation. Receipt of completed 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 thirty (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 thirty (30) days.

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

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

C7: The training requirements will be completed. Remediation within sixty (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.

☐ **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 and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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 ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

As reflected in the Statewide Transition Plan approved by CMS on February 15, 2023, the OA only utilizes non-residential provider settings and validated those settings for compliance with HCB Settings requirements during the transition period through onsite and desk validation processes prior to March 17, 2023. Settings identified as having met the institutional presumption defined in 42 CFR 441.301(c)(5)(v), requiring the application of Heightened Scrutiny, received onsite visits that included site observations as well as interviews with customers receiving services and front-line staff. Settings that did not meet the institutional presumption were required to submit evidence of compliance with all applicable HCB Settings requirements. Settings in this waiver will comply with federal HCBS requirements per Attachment #2 in this renewal application.

During the transition period, the OA updated their standard provider compliance assessment tool to monitor for compliance with HCB Settings requirements. Once every two (2) years or in response to compliance concerns, the OA conducts quality assurance assessments of ADS, TBI Pre-Vocational Service, and TBI Day Habilitation provider settings. The assessments include interviews with customers to ensure compliance with HCB Settings requirements. At initial and annual eligibility assessments, OA customers are provided with their OA 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 OA Counselors and MCO case managers during service planning and eligibility assessments. OA Counselors and MCO case managers are educated to relay provider complaints to the OA administrative office via dedicated e-mail inboxes.

The OA works with provider settings to resolve any non-compliance concerns received by the OA's administrative office or observed during quality assurance reviews. This process includes written notification to the provider setting of the non-compliance concern(s) and a timeline for remediation. 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.

Prior to enrollment as an OA-approved provider, the OA completes an initial Certification review that includes provider submission of documents reflecting compliance with OA program regulations as well as an onsite visit conducted by the OA that includes review of customer case files and training information. New provider settings cannot begin service provision until they are determined compliant with OA regulations, including regulations updated to account for HCB Settings requirements. New provider settings requiring the application of Heightened Scrutiny will have compliance evidence presented for public comment and submitted to CMS for review.

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 *(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.

OA Case Managers that are performing level of care evaluations must be:
1) A Registered Nurse, with a current license and a bachelor's degree in nursing, social work, social sciences, or counseling or one year of case management experience; or

2) A social worker with a bachelor's degree in either social work, social sciences, or counseling. A Bachelor of Social Work or a Master of Social Work degree from a school accredited by any organization nationally recognized for the accreditation of schools of social work is preferred; or

3) A human services professional with a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling) and a minimum of one year of case management experience.

In addition, it is mandatory that the case manager has:

1) Broad knowledge of community resources and networking, case management, and home care; and

2) Experience in working with racial and ethnic minorities, as well as one or more of the following:
- Domestic abuse;
- The lesbian, gay, bisexual, transgender, queer (LGBTQ+) community;
- Persons living with HIV/AIDS; and
- Persons with substance use disorders.

☐ **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. *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.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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, OA Case Manager, or MCO Care Coordinator. All utilize skills to engage customers 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, OA Case Manager, 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 his/her 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 either the HSP Rehabilitation Counselor, OA Case Manager, or 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's right to choose all persons of their choosing to be included in all PCP process 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 waiver customer is furnished with all supports necessary to enable them to actively engage in the PCP process at initial eligibility determination and redetermination. This includes providing them with information about the range of services and supports offered through the waiver in advance of PCP development and engaging individuals of the customer's choosing to assist them in a person-centered planning process. The customer and all service providers must sign the PCP, and each is provided a copy.

The HSP Rehabilitation Counselor or OA Case Manager completes a Person-Centered Service Needs Assessment Form. This is a supplemental form that incorporates the customer’s strengths, goals, risk mitigation, and reviews issues such as housing, employment, recreation, and emotional health. This supplement 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 completes an initial health risk assessment. 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 ninety (90) days of enrollment and re-assess the PCP at least every ninety (90) days, per the terms of their contract with the State. The contract also requires contact visits every ninety (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 in which the customer resides is actually chosen by the customer. It also mentions the Home and Community-Based Services (HCBS) Setting Rule is met when applicable.

The HSP Rehabilitation Counselors, OA Case Managers, and the MCO Care Coordinators are also required to offer as much choice as possible with selecting providers to accommodate customer choice. The most commonly utilized waiver service is the 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. For agency-based providers, the OA must maintain a provider network that ensures adequate providers to meet the customer need throughout the state. 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 (1) provider of such covered services, the MCO shall enter into contracts with at least two (2) 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. 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; and, (g) how and when the plan is updated, including when the participant's needs change. 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:
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 the customer's representative following the same expectations as those set by the OA for the HSP Rehabilitation Counselor or the OA Case Manager. 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 MCO 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, goals, and health status:

OA Process:
Service needs are identified by the Determination of Need (DON) assessment tool, which includes the Mini-Mental State Exam (MMSE). The DON assessment tool evaluates the customer's level of impairment in ADLs and whether the customer's care needs are met by formal or informal supports. The MMSE examines the customer's cognitive functioning. The HSP Rehabilitation Counselors and OA Case Managers utilize medical records (latest History & Physical, hospital discharge paperwork, physical therapy, and occupational therapy notes, etc.) to ensure they corroborate scoring on the DON assessment tool. An HSP Rehabilitation Counselor or OA Case Manager will not finalize a DON assessment 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 strengths, needs, and goals. HSP Rehabilitation Counselors and OA Case Managers 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, a supplement to the PCP 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 supplement is part of the PCP.

MCO Process:
The MCOs have similar comprehensive assessment tools that contain components used to elicit a wide range of information from 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 MCO Care Coordinators also review the DON assessment tool, which identifies ADLs and IADLs and need for care, that 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. MCO Care Coordinators 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 MCO Care Coordinators, like the HSP Rehabilitation

Counselors and OA Case Managers, 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 External Quality Review Organization (EQRO) reviews assessments as part of its pre-implementation record review, onsite post-implementation record review, as well as in quarterly record reviews, to ensure the assessments meet contractual requirements.

c) Informing customer of services available under the waiver:

OA Process:
As part of the determination of eligibility and redetermination process, the HSP Rehabilitation Counselor or the OA Case Manager and customer discuss the array of services, regardless of funding sources, which are available to the customer and for which the customer is eligible. It is the HSP Rehabilitation Counselor's or OA Case Manager's responsibility to explain all service options to the customer, including, but not limited to, waiver services. 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, at reassessment, and at any time a service is changed. HSP Rehabilitation Coordinators and OA Case Managers 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, such as waiver services, at the initial face-to-face visit. The MCO 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 his/her 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 the plan addresses customer goals, needs (including health care needs), and preferences:

OA Process:
The comprehensive assessment takes into consideration the customer's strengths, needs, and goals. 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 or the OA Case Manager should be one in which the customer agrees. Subsequently, the customer and the HSP Rehabilitation Counselor or OA Case Manager 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. Looking at a systems approach, it is recognized that unaddressed needs with physical health impact the delivery of long-term services and supports, just as challenges and inconsistencies in the delivery of long-term services and supports can impact health status. While the responsibility of coordination is on the customer, it is up to the HSP Rehabilitation Counselor or the OA Case Manager to raise the critical issues and help the customer problem solve with all service needs.

MCO Process:
Comprehensive assessments are completed 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 MCO Care Coordinator and the array of services have been presented to and discussed with the customer, the MCO Care Coordinator, the customer, and/or the customer representative(s) formulate a PCP that addresses the customer's goals, strengths, and barriers/risks in consideration of these goals, as well as 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, which are 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.

MCO Care Coordinators 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 or the OA Case Manager, 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, or the OA Case Manager are responsible for the identification, authorization, and assignment to the responsible service provider, in coordination with and direction from the customer and/or the customer's 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 MCO 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 MCO Care Coordinator, who is responsible for the identification, authorization, and assignment to the responsible service provider, in coordination with and direction from the customer and/or the customer's 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 or the OA Case Manager must offer a copy of the Customer’s Bill of Rights to the customer and provide any time it is requested. This brochure outlines the responsibilities of the customer and the responsibilities of the MA and OA as it relates to receiving services. Included in the customer's responsibilities is the responsibility to notify the HSP Rehabilitation Counselor or OA Case Manager of any changes in status, i.e., hospitalizations, changes in needs, changes in financial status, etc. The OA 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 HSP Rehabilitation Counselor or OA Case Manager of changes in the customer’s status. OA policies and training outline the responsibilities of the HSP Rehabilitation Counselor and the OA Case Manager. 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 customer.

The MA mandates that upon initial assessment and every assessment thereafter, the MCO Care Coordinator provides the rights and responsibilities brochure to the customer. These brochures outline the responsibilities of the customer and the responsibilities of the MA and MCO as it relates to services. Included in the customer's responsibilities is the responsibility to notify the MCO Care Coordinator of any changes in 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 MCO Care Coordinator of changes in the customer’s status. MCO policies and training outline

the responsibilities of the MCO 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's/customer's needs change:

OA Process:
The HSP Rehabilitation Counselors or the OA Case Managers conduct redeterminations of eligibility on an annual basis to review and/or revise the PCP with the customers or when there has been a change in the customer's condition. The PCP is designed to meet all needs of the customer as identified on the DON assessment tool 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 or OA Case Manager may complete a temporary service plan addendum that modifies the level of care until the next reassessment is completed. If there are new needs identified or if the new cost of services exceeds the Service Cost Maximum (SCM), the HSP Counselor or OA Case Manager will complete a new reassessment in the home.

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 Counselors and the OA Case Managers are encouraged to have a conversation with the customer to try and resolve issues. Customers have the right to appeal any decision made by the HSP Rehabilitation Counselor or OA Case Manager 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; properly completing, signing, and/or submitting necessary documentation in accordance with program guidelines; 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 the OA as soon as known.

MCO Process:
For customers enrolled in an MCO, the MCO Care Coordinator is the lead for waiver PCP development. MCO Care Coordinators are responsible to conduct reassessments on customers. At a minimum, the MCO Care Coordinator will conduct a reassessment annually for the customer. In addition, the MCO Care Coordinator will conduct a face-to-face reassessment each time there is a change in the customer’s condition, or the customer requests a reassessment. The MCO coordination staff 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 Care Coordinator 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 they will conduct reassessments as necessary based upon such reviews.

After each comprehensive assessment is completed in which the customer’s current status and needs are identified, a new PCP is completed. During the assessment and reassessments, the MCO 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 MCO Care Coordinator any time there is a change in the customer's living or medical situation that may affect the customer's need for services. The PCP can be adjusted in-between assessments to meet the customer's immediate needs. Whenever there is a change in 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 MCO Care Coordinator completes a comprehensive assessment to identify the customer’s strengths, needs, and formal and informal supports based on information provided by the customer or representative. Customers have an active role in choosing the types of services and service providers to meet those needs. The MCO Care Coordinator obtains the customer’s signature of agreement on the PCP and offers the customer a choice of providers to fulfill the services.

The MCO Care Coordinator is responsible for providing clear direction to the customer regarding the customer's 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, the customer must contact the MCO Care Coordinator and request that services remain intact. If the customer appeals within a required 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 ten (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 in the PCP development process. Several rules under the Illinois Department of Human Services' (DHS) Home Services Program (HSP) 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, in the following rules under 89 Ill. Adm. Code, Part 676, Program Description; Part 677, Customer Rights and Responsibilities; Part 684, Service Planning and Provision; and Part 686, Provider Requirements, Type Services, and Rates of Payment. The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

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 or OA Case Managers 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 or OA Case Manager and customer discuss a wide range of domains that may mitigate the risk. These domains include issues that impact the success of the waiver services, or any other formal or informal supports 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, and/or 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 occurs between the HSP Rehabilitation Counselor or the OA Case Manager and the customer during initial assessment and subsequent reassessments. The customer is assessed with respect to risks and potential risk factors and the ability to address any identified risks in the PCP. Severity of impairment is determined through the HSP Rehabilitation Counselor or OA Case Manager 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 IPs or homemakers to make additional meals for storage and reheating during times of inclement weather.

Every PCP using IPs must have a backup plan. The backup plan utilizes programs, services, and resources identified by the customer and HSP Rehabilitation Counselor or OA Case Manager. 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.

The HSP Rehabilitation Counselor or OA Case Manager works with the customer to develop a backup plan that could include using natural supports, non-paid caregivers, another IP, or an agency provider. Customers are encouraged to obtain two IPs that are familiar with their needs so 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 IP, the HSP Rehabilitation Counselor or OA Case Manager can authorize homemaker services to ensure services remain intact during the hiring process.

MCO Process:
For customers enrolled in an MCO, the MCO Care Coordinator is the lead for PCP planning. The assessment for potential risk is included in the PCP process. The MCO Care Coordinator is expected to incorporate and utilize the same strategies as described above in the development of the PCP. In addition, the MCO coordination staff 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 MCO Care Coordinator develops the backup plan and works with the customer to ensure necessary arrangements are in place.

The MCO 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, or the abuse of alcohol or other substances, including illegal substances and medications; providing a crisis safety plan for a customer with a behavioral health condition; role of caregivers; physical health; and occurrences and risks of falls. These are explored and addressed as they may increase and serve as barriers to the customer's ability to live as safely and independently as possible. All risks are identified and discussed in the PCP process. Interventions are developed to mitigate identified risk(s) and barriers and are mutually agreed upon by the customer and the MCO 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:
The OA provides a brochure is provided to new applicants that describes all waiver services. HSP Rehabilitation Counselors or OA Case Managers assist customers in choosing services and service providers. Over 85% of the providers in the HSP program are IPs that are hired and trained by the consumers. HSP Rehabilitation Counselors and OA Case Managers assist customers in identifying potential IPs, as well as agency providers. When an IP is chosen, a packet of information is given to the customer that includes information on self-direction, including a Customer Handbook, Customer's Rights and Responsibilities document, and IP Standards forms. HSP Rehabilitation Counselors and OA Case Managers receive intensive training on the array of services provided by the waiver. Additionally, both receive the rates and fee table that lists all service descriptions.

Occasionally customers may have difficulty locating IPs, or they may simply prefer services from an agency. In these situations, HSP Rehabilitation Counselors or OA Case Managers provide ideas and other potential resources for customers to find available workers. The OA Case Manager works to ensure continued access to potential IPs and to ensure that other services, such as agency services, are available when IPs are unavailable to assist a customer.

If an agency provider is chosen, the customer is provided with a list of available providers and offered the opportunity to select a preferred provider. Each provider is also encouraged to have its own brochures and advertising materials available upon customer or counselor request. Customers and families are encouraged to visit agency providers before choosing them.

MCO Process:
For customers enrolled in a MCO, the MCO Care Coordinator is the lead for waiver PCP development. The MCO 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 MCO Care Coordinator's role to provide information about the available services and service providers and to answer any questions of the customer. The MCO Care Coordinator assists the customer by supplying qualified provider information relevant to the services available in the service area that are selected by the customer. The MCO Care Coordinator informs and supports the customer in selecting a provider to meet the customer's needs, particularly if the customer does not have a preferred provider identified. The MCO Care Coordinator maintains a current list of qualified 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 in each county within the contracting area to assure 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 (1) provider of such covered services, the MCO shall enter into contracts with at least two (2) such providers, so long as such providers accept MCO rates, even if one served more than 80% of the customers, unless the MA grants the MCO an exception. It is the MA's goal that this will ensure choice on behalf of the 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 Person-Centered Plan (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 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 Quality Improvement Organization (QIO) monitors the OA and an External Quality Review Organization (EQRO) monitors MCOs.

The QIO determines a review schedule, based on the sample, and performs onsite record reviews to assess compliance with the Performance Measures (PMs), as well as with all applicable state and federal requirements. Reports of findings are shared with the OA by individual PM. Remediation of findings are completed according to the required actions related to each PM. Timeliness of remediation is reported back to the MA based on the requirements of each PM, either immediate, thirty (30), sixty (60), ninety (90), or greater than ninety (90) days, and for any remaining outstanding remediation. Information related to onsite record reviews is also shared during quarterly meetings between the MA and OA.

For the MCOs, the EQRO determines a review schedule, based on the sample, and performs onsite record reviews to assess compliance with the performance measures (PM), as well as with all applicable state and federal requirements. Reports of findings are shared with the MCO by individual PM. Remediation of findings are completed according to the required actions related to each PM. Timeliness of remediation is reported back to the EQRO, and MA based on the requirements of each PM, either immediate, thirty (30), sixty (60), ninety (90), or greater than ninety (90) days, and for any remaining outstanding remediation. Information related to onsite record reviews is also shared during quarterly meetings between the MA and MCOs.

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 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 service plan 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 and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

MA Process:
The OA and the MCOs have responsibility for the completion and implementation of the PCP, including non-waiver-based services, 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 the PCP is updated when a significant change in customer condition or need occurs. MA oversight is completed through onsite monitoring using a statistically valid representative sampling methodology with 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 QIO monitors the OA and an EQRO monitors MCOs. 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 PMs, 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 PMs, 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 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 or OA Case Manager 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 Counselors or OA Case Managers meet face-to-face with customers every other month, at a minimum, and as needed based upon 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 customer's overall health and welfare by the methods detailed below.

For customers using homemakers and agency providers, the HSP Rehabilitation Counselor or OA Case Manager 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 HSP Rehabilitation Counselor or OA Case Manager will follow-up with the customer and if necessary, adjust the PCP as needed.

For customers who have IPs, the HSP Rehabilitation Counselor, OA Case Manager, 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 or OA Case Manager will follow-up with the customer to rectify the situation.

The HSP Rehabilitation Counselors and OA Case Managers review 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 or OA Case Manager to resolution.

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

Each MCO continuously monitors implementation of the PCP and ensures updating occurs as needed through internal quality assurance monitoring. The MCO 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 customer's overall health and welfare by the methods detailed below.

For customers using homemakers, agency providers, or IPs, the MCO 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 MCO 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 MCO Care Coordinator will follow-up with the customer to rectify the situation.

The MCO 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 MCO Care Coordinator to resolution.

Through its contract with the EQRO and QIO, the MA monitors both compliance of PMs and timeliness of remediation. A report of findings is provided to the MA, OA, and MCOs at the conclusion of each record review. The report consists of a summary of findings for each customer record reviewed, and a summary of overall findings detailed by performance measure and contractual requirements reviewed. Remediation activities are tracked by the MA, OA, EQRO, and QIO to ensure 100% remediation of findings. Timeframes for completion of remediation are reported in thirty (30), sixty (60), ninety (90), or greater than ninety (90) days. Remediation activities are to be consistent with the approved activities detailed within each performance measure. The MA and OA work collaboratively to follow-up with the OA offices and MCOs to ensure remediation occurs within the required time frames.

Through its contract with the EQRO and QIO, the MA monitors both compliance of PMs and timeliness of remediation from quarterly record reviews. A report of findings is provided 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.

b. Monitoring Safeguards. *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.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

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 customers' 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 *(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:
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: 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:
D4: Number and percent of OA and MCO customers who have Individual Provider

(IP) services whose Person-Centered Plans (PCP) included a backup plan. N: Number of OA and MCO customers who have IP services whose PCP included a backup 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: # and % of OA customers who received monthly contact & bi-monthly face-to-face contact by HSP Rehabilitation Counselor (RC)/OA Case Manager (CM) to monitor service provision or gap in service delivery. N: # of OA customers who received monthly contact & bi-monthly face-to-face contact by HSP RC/OA CM to monitor service provision or gap in service delivery. D: Total # 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 & percent of MCO customers who received monthly contact and bi-monthly in-person contact by MCO Care Coordinator to monitor service provision or gap in service delivery. N: Number of MCO customers who received monthly contact and bi-monthly in-person contact by MCO Care Coordinator to monitor service provision or gap 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: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

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: 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:
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: 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:
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 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.

On an annual basis, DHS/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.

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 PMs, which are specified in HFS' contracts with 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 an 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. 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, the OA Case Manager, or MCO Care Coordinator. Remediation must be completed within sixty (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, the OA Case Manager, or MCO Care Coordinator. Remediation must be completed within sixty (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, the OA Case Manager, or MCO Care Coordinator. Remediation must be completed within sixty (60) days.

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

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

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

D7: If PCPs are untimely, the OA/MA will require completion of overdue PCPs and justification from the HSP Rehabilitation Counselor, OA Case Manager, or MCO 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 training. Remediation within sixty (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 sixty (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 Rehabilitation Counselor, OA Case Manager, or MCO Care Coordinator. If the issue appears to be fraudulent, it will be reported by the OA/MA. Remediation must be completed within sixty (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 HSP Rehabilitation Counselor, OA Case Manager or MCO Care Coordinators. Remediation must be completed within sixty (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. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

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 (HSP) since the early 1980 and in the Persons with HIV or AIDS waiver since its inception in 1990. 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 well, HSP Rehabilitation Counselors or OA Case managers work closely with customers to verify services are being provided in accordance with the Person-Centered Plan and to the satisfaction of the customer. HSP Counselors or OA Case Managers contact customers at least once monthly by phone and every other month face-to-face to discuss services and any changes in their living situation.

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 for the four Chicago districts, which serve the majority of those in the HIV or AIDS waiver, are sent to the HSP Ashburn Unit for further verification and payment. In Central and Southern IL, timesheets are forwarded to the OA district office for processing. 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 towards eliminating timesheets and using EVV only.

IP services are provided in accordance with the PCP. In the event 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 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 that is authorized to provide services, but they 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 with 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 HSP Ashburn Unit.

For customers enrolled in a Managed Care Organization (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 (FFS) 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*:

- [x] **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 PCP development process, the HSP Rehabilitation Counselors or OA Case Managers provide information to customers about customer directed services and choice of workers. Customers are given a “Customer Hiring a Provider - Document Packet”, which includes information about managing an IP, information about how to file an appeal, an HSP Fraud Brochure, and information required to enroll an IP.

Information is also provided to customers regarding Centers for Independent Living (CILs) and opportunities for IP training:

The OA contracts with 24 CILs in Illinois to train and refer (IPs) to HSP customers, including those in the waiver for persons with HIV or AIDS. Training includes an orientation to the HSP, the independent living philosophy, an overview of disabling conditions, assistance in daily living, and employment considerations. A CIL is a non-residential, community-based organization that provides resource and advocacy services to persons with disabilities. At least 51% of CIL staff and board members are persons with disabilities.

The IP packet includes the following: Medicaid Waiver Provider Agreement form, Individual Provider Standards, Individual Provider Payment Policies, Illinois Medicaid Program Advanced Cloud Technology (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 or OA case managers 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 or OA case manager 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 or OA case manager 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 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 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 or OA Case Managers contact customers monthly by phone. Every other month, they make a face-to-face visit. Customers are provided with an information folder which includes information about their case, their appeal rights, and DHS contact information. Customers are advised to contact the HSP office if their situation changes, any time there is a problem, or if there is a change in need for service.

MCO Care Coordinators contact the customer contact customers monthly by phone. Every other month, they make a face-to-face visit. Provision of services is discussed with the customer or the customer's designee, as well as changes in the home, increase or decrease of need, medical information including participation and response to treatment, as well as other issues that may affect the customer's ability to live in the home. This information is documented in WebCM case notes and is available to HSP Rehabilitation Counselors, as well as MCO Care Coordinators, for viewing.

HSP Rehabilitation Counselors, OA Case Managers, 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, OA Case Managers, and MCO Care Coordinators believe 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 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 him/her in decision making or navigating the waiver and health plan services.

If the customer can direct his/her 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 and informal supports are being provided as previously identified in the assessment, and other contacts may be done by the HSP Rehabilitation Counselor or OA Case Managers to ensure service implementation and well-being of 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
Intermittent Nursing	☒	☐
Respite	☒	☐
In-Home Shift Nursing	☒	☐
Home Health Aide	☒	☐
Individual Provider	☒	☐

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 utilized by the 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 IPs 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 utilized 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 OA and the 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 instances 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 the correct rate being 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 HIV or AIDS 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 89 IL. Adm Code 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 and OA Case Managers are responsible for providing information and support to customers. Customers' 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.

Community-based OA case management agencies are located throughout the state. There are 16 case management offices, statewide. OA case management agencies are responsible for providing information and support to customers and are reimbursed monthly per case. Although not specifically reimbursed for provision of information and assistance, the monthly stipend paid to case management agencies covers this activity.

Customers using 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 4/2018) 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 an MCO, the MCO Care Coordinator is the lead for waiver 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 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
Environmental Accessibility Adaptations	☐
Physical Therapy	☐
Adult Day Service	☐
Homemaker	☐
Specialized Medical Equipment and Supplies	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Emergency Response System	☐
Intermittent Nursing	☐
Respite	☐
Occupational Therapy	☐
In-Home Shift Nursing	☐
Home Health Aide	☐
Speech Therapy	☐
Individual Provider	☐
Home Delivered Meals	☐

☒ **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:

Information about customer direction is provided to customers by HSP Rehabilitation Counselors and OA Case Managers, as well as by advocates located in Centers for Independent Living (CILs). HSP administration provides ongoing support and consultation to OA case management staff to facilitate their support of customer direction.

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

At each redetermination, the HSP Rehabilitation Counselor or the OA Case Manager 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 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 an 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. 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 FFS 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 (IDoA) offers an independent entity called the Home Care Ombudsman Program 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.

The Home Care Ombudsman Program 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 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 PCP development process, the HSP Rehabilitation Counselor or the OA Case Manager reviews 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 the customer's family members.

If the customer has the capacity to self-direct and chooses an 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 the customer may choose an agency-based provider to provide services.

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 or the OA Case Manager 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 ten (10) days of receiving the adverse determination letter. When transitioning from self-directed to agency-based services, the HSP Rehabilitation Counselor or OA Case Manager assures that there are no disruptions in services.

The CIL, in conjunction with the OA, provide training to assist customers in the management of 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 participates 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 an 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 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 his/her services can obtain 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 or the OA Case Manager that the customer can effectively supervise the IP. In cases where the HSP Rehabilitation Counselor or OA Case Manager 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 or OA Case Manager will acquire homemaker services through an agency-based provider. These services will be provided in accordance with the PCP.

For customers enrolled in a 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 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 the customer's service is being terminated or reduced and includes the customer's 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 the customer's 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 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's, OA Case Manager, 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 its 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 the needs of the customer and when it is appropriate to change from an IP to an agency-based provider. The MA and OA do not specifically monitor the decisions that are made by the MCOs.

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 IP will only be provided when it has been determined by the Home Services Program (HSP) Rehabilitation Counselor or OA Case Manager that the customer has the ability to supervise the IP. In cases where the HSP Rehabilitation Counselor or OA Case Manager 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 or OA Case Manager will acquire services through an agency-based provider. These services will be provided in accordance with the PCP.

For customers enrolled in a 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 the service is being terminated or reduced and includes the customer's 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's 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 communication or decision-making ability, the HSP Rehabilitation Counselor, the OA Case Manager or the MCO Care Coordinator may determine that the customer does not have the capacity to self-direct 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's, OA Case Manager, 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, the OA Case Manager, 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 its 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 MA 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	1200	
Year 2	1200	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 3	1200	
Year 4	1200	
Year 5	1200	

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:

The co-employer is the State of Illinois, Division of Rehabilitation Services.

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 or OA Case Manager before they choose services.

For the FFS 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 an 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 MA and the OA. The fair hearings process is the same for all customers, including those enrolled with MCOs.

Examples 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 or OA Case Manager 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 sixty (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 Ill. Adm. Code, Sections 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/DRS 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, Part 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 PCP developed for him/her as a result of the original determination of eligibility or redetermination of eligibility.

When a HSP Rehabilitation Counselor or OA Case Manager 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 fifteen (15) days prior to the effective date of the action. The HSP Rehabilitation Counselor or the OA Case Manager 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 a 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 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 a 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 or to deny a requested service or to reduce, suspend, or terminate a previously authorized service, a Notice of Adverse Determination is provided by the MCO in writing to the customer and authorized representative, if applicable. In addition, the MCO 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 grievances 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 about whether the appeals were upheld or overturned. Appeals are reported separately for each Waiver. The MA reviews and analyzes the grievances 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 the 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 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 the 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 the customer's choice, The appeal process is described in writing in the MCO's customer handbook which is reviewed with the customer by the MCO's Care Coordinator.

When services are denied, reduced, suspended, 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; and (c) the guidelines or criteria used in making the decision. The Notice of Adverse Determination also contains information on appealing the determination and how services can continue during the period while the customer's appeal is under consideration. The customer is also informed of the right to request, free of cost, access to all copies of relevant information.

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

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

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**

b. 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, and this may even occur after the hearing. The informal resolution conference may be requested by contacting the office from which the customer receives services (Customers Guidance on Rights/Responsibilities/Appeals Procedures; 89 Ill. Adm Code, Section 510.100, Informal Resolution Conference). The customer is informed that the informal resolution conference is not required, and it is not a pre-requisite or substitute for a fair hearing.

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 the customer's concerns. The informal resolution conference is conducted by the OA central office staff and includes the OA Counselor or OA Case Manager and customer, as well as 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 HSP of the OA to schedule hearings. The hearings are scheduled according to availability of all parties. At least three (3) 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 ninety (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 is reviewed annually. Since then, DHS and HFS have a new shared case management system, Integrated Eligibility 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**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint

system:

The Department of Human Services (DHS), Division of Rehabilitation Services (DRS) is responsible for operating the grievance/complaint system. This system is discussed in section F-1: Opportunity to Request a Fair Hearing.

For customers enrolled in a MCO, the MCOs shall establish and maintain a procedure 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.

c. 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) For the FFS population, grievances and complaints are handled through the same system as the administrative hearings. If a customer is dissatisfied with any action or inaction taken by an OA employee, OA Case Manager, or service provider, a customer may file a grievance/complaint by either contacting the local OA office or by mailing, faxing, or emailing the complaint directly to the OA's Division of Administrative Hearings. The customer is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing. The complaint must be filed within thirty (30) calendar days following the date the customer is notified of the action, or thirty-five (35) calendar days from the date postmarked on the notice that had been mailed to the customer. The OA provides customers the opportunity to participate in an informal resolution conference to resolve issues that do not raise to the level of a formal hearing or can be resolved prior to the hearing. Ombudsman services are also available, when requested. A Home Care Ombudsman may assist a customer who has requested assistance with grievances. In order to do this, the customer must provide consent by completing the Authorized Representative Form.

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. 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 a 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 forty-eight (48) hours. The MCO has no longer than ninety (90) days to resolve the grievance, and the MCO may inform the customer of their decision verbally or in writing.

(b) DRS administration maintains and monitors an unusual incidents database on an ongoing basis. Data is reviewed and analyzed by DRS administration to identify trends or issues requiring further investigation. Results of this review are shared with HFS administration at least annually. Any trends and/or patterns determined from data analysis will be addressed by DRS and HFS as needed or during quality management meetings. Upon receipt of a grievance or complaint, the HSP Rehabilitation Counselor or OA Case Manager immediately completes a Critical Incident Report (CIR) that is disseminated to appropriate DHS administrative personnel. Again, if the issue involves possible abuse and neglect, Adult Protective Services is notified as well.

(c) 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 by the HSP Rehabilitation Counselor or the OA Case Manager. For instances in which the HSP Rehabilitation Counselor or OA Case Manager is accused of misconduct, a CIR (complaint) would be filed, and the customer would also have the option of filing an appeal if the conduct resulted in an adverse case decision.

For customers enrolled in a 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 ninety (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 a 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. MCOs also discuss the grievance and appeals process with the customer during the PCP process.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

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

DHS/DRS administration is responsible for ensuring that all Critical Incident (CI) reports are processed in a timely and appropriate manner. Immediately upon receipt of an unusual incident report, it is shared with the designated unit within DRS that is responsible for coordinating these investigations. 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, it is determined whether immediate agency action is required. If so, the HSP Rehabilitation Counselors and OA Case Managers are provided with specific instructions on any actions to pursue. Any direction received from Adult Protective Services is also acted on immediately. Throughout this process, OA's Fraud Unit staff work directly with DRS central office staff, as well as the local HSP Rehabilitation Counselor or OA Case Managers, 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 (18):
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 eighteen (18).

The types of 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 (e.g., 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 (7) 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 MA and the waiver OA, law enforcement personnel, coroner/medical examiner personnel, childcare 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 aged eighteen (18) and older:
Adult Protective Services (APS)

The processes defined under APS are the same whether the waiver customer receives care coordination through the state, the HSP Ashburn Unit or through managed care.

Public Act 94-1064 amended the Elder Abuse and Neglect Act, changing the name of the entity to APS, 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 sixty (60). In addition, the Adult Protective Services Act (320 ILCS 20/1 et seq.) authorized the IDoA to administer the APS unit to respond to reports of abuse for all non-institutionalized adults that meet this criterion. 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 (7) 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 types below 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 IL. Adm Code 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 Ill. Adm. Code, Part 270.

Reporting:
More information and brochures [Adult Protective Services Act and Related Laws and What Professionals Need to Know] may be found at: https://ilaging.illinois.gov/resources/newspublicationsandreports/publications/elderrights.html

Mandated Reporters:
The Illinois Adult Protective Services Act (320 ILCS 20/1) requires personnel of the Operating Agency (OA) and 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 Ill. Adm. Code, Section 270.230.

Reporting Timelines: Follow-up Actions by IDoA can be found at: 89 Ill. Adm. Code, Section 270.240, Intake of ANE Reports.

Rules may be accessed at IDoA's website at: https://ilaging.illinois.gov/aboutus/rules-main.html

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. HSP Rehabilitation Counselors, OA Case Managers, 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 or OA Case Managers are made aware of the incidents, they are reported to the central office, and an OA Rehabilitation Counselor or OA Case Manager is assigned to the case. OA Rehabilitation Counselors and OA Case Managers assist with reporting and remain involved in the case to ensure the customer is safe from harm and that an adequate 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 in 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
• Unanticipated Death

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

All incidents will be reported to the compliance officer or designee and entered into the MCO's CI report database. Based on the situation, the customer's age and placement reports will also be made to the appropriate State of Illinois investigative agencies.

The MCO Care Coordinators will continue to provide the customer, or the customer's family or representatives, information about his/her rights and protections, including how the customer 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.

HSP Rehabilitation Counselor, OA Case Managers, and MCO Care Coordinator are required document all CIs in their electronic system immediately for action, monitoring, tracking, and resolution. Other waiver service providers report CIs to the OA or MCO, whoever authorized their services. Allegations of abuse, neglect or financial exploitation, for adults are reported immediately to 24-hour APS Hotline or local APS office during regular business hours. Allegations suspected child maltreatment in children are reported immediately to the DCFS 24-hour hotline. Local authorities are immediately alerted, as warranted.

All CIs are to be reported immediately upon discovery however, CIs that are reported after normal business hours will be responded to the next day during business hours.

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 Counselor or OA Case Manager 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 or OA Case Managers 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 with 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 required for operating and maintaining a HCBS Waiver.

Through an ongoing basis, the MCO Care Coordinators 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 providers 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 customers 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 eighteen (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 plans, 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 twenty-four (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 sixty (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, to 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, 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 (5) years, for twenty (20) years if there was serious physical injury, and for fifty (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 thirty (30) days and up to three years, depending on the seriousness of the situation.

Customers aged eighteen (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 at 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 OA Case Manager, the 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 or OA Case Manager.

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 Ill. Adm. Code, 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 twenty-four (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 than priority one reports. The caseworker must make a face-to-face visit within seventy-two (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 seven (7) calendar days of the receipt of the report.

The APS requires that all Priority I incidents be at least temporarily corrected within twenty-four (24) hours, and a permanent correction must occur within sixty (60) days. All other events must be corrected within sixty (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 Ill. Adm. Code, 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 or OA Case Manager 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 twenty (20) calendar days. Within that time, the MCO Care Coordinator will work with both APS and the customer to review and, if applicable, update the current PCP to reflect the customer's 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, the HSP Rehabilitation Counselor, the OA Case Manager, 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; and/or
• Emergency responses for housing, food, and physical and mental health services.

The MCOs are expected to provide any services that APS recommends that fall within managed care coverage and refer for services outside managed care 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 CIs 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, where the CIs for the HCBS waiver population are broken out by waiver.

APS Reporting:
State requirements for reporting of abuse, neglect, or financial exploitation of customers aged 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 sixty (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 twenty-four (24) hours a day, seven (7) days a week;
888-206-1327 (TTY)- available twenty-four (24) hours a day, seven (7) days a week;
Senior HelpLine number, 1-800-252-8966- available during regular business hours. After-hours 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.

The MA and OA are responsible for overseeing the operation of the incident management system. The OA is responsible for overseeing the operation of the incident management system customers not enrolled in managed care. The MA is responsible for overseeing the operation of the incident management system for the MCOs.

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 Case Management for follow up. The OA Fraud Unit maintains a database in order to track responses.

Critical Incident (CI) reporting is now completed electronically. 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 IP/customer issues. All OA CI 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 Division 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 MA and OA at quarterly Quality Assurance meetings. The MA attends the CI review during each MCOs quarterly record review. The EQRO submits a report of CIs following each review to the MA. The MA attends the CI review during each MCOs quarterly record review. The EQRO submits a report of CIs following each review.

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 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 DCFS is contacted.

In addition, the OA Fraud Unit works with the local OA field office staff to ensure proper resolution. CIs are monitored by HSP administration on an ongoing basis. Data is reviewed 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 seven (7) calendar days after the report. Reports of exploitation shall be assessed within thirty (30) calendar days after the report is received. Reports of abuse or neglect indicating the life or safety of an adult diagnosed with HIV/AIDS 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 MCO to develop, with the consent of and in consultation with the adult diagnosed with HIV/AIDS, a PCP to address the person’s needs.

The OA Fraud Unit contacts appropriate field personnel to request follow up on an allegation and to request an update on attempts to resolve the situation. Field personnel indicate whether or not an internal investigative review has been completed, as well as 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 CI 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 CI 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. 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 a MCO, the MCOs will maintain an internal reporting system for tracking the reporting and responses 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 a MCO. Customers in MCOs are included in the representative sampling.

The CI reports from the MCOs and OA details the type of CIs tracked, trend analysis are related to the types of incidents, customer characteristics, providers, how quickly reports are reviewed and investigated, how promptly follow-up takes place, the results of investigations, and whether participants are informed of the investigation results. The MA attends the CI review during each MCOs quarterly record review. The EQRO submits a report of CIs following each review.

Along with the discussion of trend analysis, the MA, OA, and each MCO discusses strategies to reduce the occurrence of critical incidents and opportunities for system improvement. Based upon trends, the OA and MCO policies and procedures for reporting of critical incidents are also reviewed and updated as needed to ensure policies are being followed and that follow-up is being conducted on a timely basis.

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 OA administration via the unusual CI reporting procedure. Simultaneously, an alleged incident would be reported to the proper authority for review.

For customers enrolled in an 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 OA HSP Rehabilitation Counselors, the OA Case Managers, and MCO Care Coordinators are responsible for detecting the unauthorized use of restraints and assuring customer's health, safety, and welfare. The use of unauthorized use of restraints is monitored through face-to-face visits and routine phone contacts with the customer and through reports by providers, family, or friends, as well as through the analysis of complaints or incidents. Telephonic and face-to-face contacts alternate monthly.

(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 CI reporting procedure. Simultaneously, an alleged incident would be reported to the proper authority for review, including the DCFS or the APS Unit of the Illinois Department on Aging.

For customers enrolled in an 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 OA HSP Rehabilitation Counselors, OA Case Managers, and MCO Care Coordinators are responsible for detecting the unauthorized use of restrictive interventions and assuring customer's health, safety, and welfare. The use of unauthorized use of restrictive interventions is monitored through every other month face-to-face visits and routine phone contacts with the customer and through reports by providers, family, or friends, as well as through the analysis of complaints or incidents. Telephonic and face-to-face contacts alternate monthly.

○ **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 HSP Rehabilitation Counselors, the OA Case Managers, and the MCO 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 APS Unit for investigation.

The OA HSP Rehabilitation Counselors, the OA Case Managers, and MCO Care Coordinators are responsible for detecting the unauthorized use of seclusion and assuring customer's health, safety, and welfare. The use of unauthorized use of seclusion is monitored through every other month face-to-face visits and routine monthly phone contacts with the customer and through reports by providers, family, or friends, as well as through the analysis of complaints or incidents. Telephonic and face-to-face contacts alternate monthly.

○ **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)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

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)*

ii. 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).

iii. 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:

iv. 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. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G1: # and % of records 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/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. D: Total # of records reviewed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G2: # and % of unexplained 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:
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**

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:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
G4: Number and percent of critical incident trends where systemic intervention was implemented. N: Number of critical incident trends where systemic intervention was implemented. D: Total number of critical incident trends.

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

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

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

Data Aggregation and Analysis:

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

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

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**	☒ **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:

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**	☒ **Annually**

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

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:

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

The MA will conduct routine programmatic and fiscal monitoring for both the 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 CIs, the MCOs are required to report 100% of the findings and remediations. 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 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 EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver customers enrolled in a 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. 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 thirty (30) days.

G2: The OA/MCO will follow up on unexplained deaths and outstanding APS referrals and DCFS reports of substantiated incidents. Changes in customer's PCP, corrective action plans, or provider sanctions will be made when needed.

Remediation must be completed within thirty (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 thirty (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 thirty (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 thirty (30) days.

G7: If identifying information is available for customer surveys, the HSP Rehabilitation Counselor, OA 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, OA Case Manager, 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 twelve (12) months. If not, barriers will be identified and addressed. Remediation will occur at the meeting between the customer and HSP Rehabilitation counselor, the OA Case Manager, 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 §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 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, 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 Quality Improvement Strategy 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 Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

The Medicaid Agency (MA), Operating Agency (OA), and Managed Care Organizations (MCOs) 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 Appendix A, Waiver Administration and Operation. 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 HIV or AIDS waiver Quality Management System (QMS) plan is part of an overall quality management plan for the three 1915 (c) waivers operated by the the Department of Human Services, Division of Rehabilitation Services (DHS-DRS), the (OA). The other waivers include the Persons with Brain Injury Waiver (control number IL.0329) and the Persons with Disabilities Waiver (control number IL.0142). 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 Quality Improvement Organization (QIO) reviews with the OA, as well and the review site, and External Quality Review Organization (EQRO) reviews with the MCOs.

On a quarterly basis, the MA conducts separate Quality Management Committee (QMC) meetings with the OA and the MCOs to review performance measure (PM) 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 PMs. Data reported includes level of compliance and timeliness of remediation based on immediate, thirty (30), sixty (60), ninety (90) day, and greater than ninety (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 PMs 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 timeliness 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**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The processes Illinois follows to continuously evaluate, as appropriate, effectiveness of the QMS is the same as the processes to evaluate the information derived from discovery and remediation activities. The Waiver 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 QMS. There will be five (5) primary focus areas 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 are evaluated to determine its effectiveness.
5) Performance Measures: The entities will determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures will also be reviewed for effectiveness, including the frequency of data collection, source of data, sampling methodology, and remediation.

The MA will continually strive to increase the compliance rate of each performance measure. While the target compliance rate for each performance measure is 100%, the State realizes that it may take multiple system changes over several years to reach the goal of 100% compliance.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

a) Requirements concerning the independent audit of provider agencies:
The Department of Human Services-Division of Rehabilitation Services (DHS-DRS) completes an onsite review of each Homemaker and Adult Day Service (ADS) provider at a minimum of every two (2) years to ensure compliance with contractual requirements. The review cycle begins the date the provider has been certified by the Operating Agency (OA). 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 89 Ill. Admin. Code, Part 686, Provider Requirements, Type of Services, and Rates of Payment. Homemaker and ADS Agencies are required to engage an independent certified public accounting agency to 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 provider's agency's expense. Agency scrutiny is triggered in several situations, including where there are complaints about no-show homemakers and when Individual Providers (IPs) bill for more services than are on the PCP. Agency scrutiny is also 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 the information may be inaccurate. The OA has also noted instances where agencies have tried to double and triple bill for the same month or for the same customer and bill for customers no longer being served or who were never being served.

30 ILCS 5/3 specifies the jurisdiction of the Auditor General and section 3-2 identifies the mandatory post audits. The Auditor General shall conduct a financial audit, a compliance audit, or other attestation engagement, as is appropriate to the agency's operations under generally accepted government auditing standards. In conjunction with the Department of Healthcare and Family Services' (HFS'), the Medicaid Agency (MA) portion of the Statewide Single Audit, a sample of provider billings for Medicaid payments that may include billings for Medicaid payments for waiver services is reviewed. The Illinois Office of Auditor General is responsible for conducting the financial audit program.

i. Per 89 Ill. Admin. Code Section 686.10, Individual Provider (IP) Requirements, IPs must demonstrate that they meet the required qualifications in several forms which must be signed by IP and customer and turned in to the waiver program as the first part of the OA provider enrollment process. This includes the IP Standards form as well as the IP Payment Policies form.

ii. On one (1) of these two (2) forms, the IP must assure that he/she will provide services in accordance with the customer's Person-Centered Plan (PCP) which specifies the frequency, amount, and duration of services to be provided. This form also requires the IP to assure he/she will abide by the limits of service provision as also specified in this section of the Ill. Admin. Code.

iii. The waiver program continues to use an Electronic Visit Verification (EVV) system as a means to better assure that IPs are in the customer's home at the beginning and end of work shifts. Personal care services 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's PCP. Completion of forms to use the EVV is another part of OA provider enrollment.

Homemaker, individual provider, respite, home health aide, intermittent nursing, occupational therapy, physical therapy, speech therapy and in-home shift nursing services are subject to EVV. Such assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs), which includes assistance with daily activities such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housekeeping, medication management, etc. Personal care may be furnished in the home or outside the home.

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/her satisfaction with the 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. EVV is used for financial integrity and accountability. The OA receives monthly reports clock-in/out data from EVV for dates of service 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 correct tasks for eligible customers are followed up on promptly. Any inappropriate payments must be repaid and backed off the 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 future services in the program.

The OA requires independent annual audits in compliance with 89 Ill. Admin. Code Section 686.100 ADS Provider Requirements and Section 686.250 Financial Reporting of Homemaker Service Providers. ADS and Homemaker providers must provide the licensing agency, the Illinois Department on Aging (IDOA), an annual audit report to be completed by an

independent Certified Public Accountant in accordance with 74 Ill. Admin. Code Part 420, Subpart D. The audit report shall be filed at the main office of IDoA in Springfield, Illinois, within six (6) months after the date of the close of the provider's business FY. The OA obtains these reports directly from the provider. The OA and the licensing agency, IDoA, also communicate when there are provider compliance issues. A special review may be conducted based on these communications.

On-site compliance reviews are conducted on 100% of the ADS providers and homemaker agencies every two years. After agencies apply for enrollment as a waiver provider, a certification review (preliminary record review) is completed on that agency, in addition to other IMPACT enrollment requirements. The certification review is completed by a Rehabilitation Service Advisor using the same review instrument utilized for existing providers during bi-annual compliance reviews. The OA conducts a preliminary record review of 100% of the waiver customers serviced by the provider to identify red flags. If issues are found, those cases are pulled and reviewed onsite. Examples of red flags include inconsistent attendance, no attendance by customer with conflicting billing data, 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 (10) cases. If the provider serves fewer than 10 customers, all records are reviewed. If there are more than ten, a ten percent (10%) random record review is selected with the floor of ten (10) cases. The period reviewed is based on the previous fiscal year. To ensure 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 verified prior to enrollment as a Medicaid provider. During onsite compliance reviews, each customer record in the sample is reviewed to determine that sufficient documentation exists to substantiate that services were actually provided. Customer records are reviewed for accuracy of completion including signatures of the customer, worker, and supervisor and accurate total number of units. OA staff also compare the number of units billed by the provider agency for that month to the PCP and service authorization. On-site and desk audit compliance reviews are not conducted for providers other than ADS and homemaker agencies. The OA reviews all agency providers at the time of revalidation in order to verify agency provider eligibility.

b) The financial audit program 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 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 HIV or AIDS 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, 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 Information Technology (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 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 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.

CONTINUED IN 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. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

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 in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

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***
☐ ***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 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 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'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 select 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 OA claim to Medicaid administrative costs.

For the waiver claims review, MA staff utilize the EDW query capability to analyze the entire data set 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 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 external quality review organization (EQRO), the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in a MCO through consumer surveys and quarterly record reviews. Participants 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. 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 thirty (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 thirty (30) days.

I3: The MA will require the OA to correct the incorrect rate. If necessary, it will also adjust federal claims submitted. Remediation must be completed within thirty (30) days.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) ***No***
- ( ) ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The 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 public input process is described in Main 6-I.

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 proposed rates and methodology with HFS for 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 through the OA's website at: https://www.dhs.state.il.us/page.aspx?item=83520.

Individual Provider (IP):
Individual Providers are defined as Personal Assistants (PAs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs), or Certified Nurse Assistants (CNAs). The Person-Centered Plan (PCP) identifies which types of Individual Providers. IPs will be used to meet a customer's needs. An agreement with Service Employee International Union (SEIU) provides that hourly direct care staff rates receive periodic flat rate adjustments. The rates are established through negotiation between the OA and SEIU. It is anticipated that negotiations will be held during summer 2023. Anticipated effective dates of the contract will be 7/1/2023 through 6/30/2028. In accordance with recent Fair Labor Standards Act (FLSA) regulations, the State allows for overtime and travel reimbursement to IPs. The rates do not include any direct or indirect admin costs, are not geographically based, and exclude room and board costs. Rates and labor agreement are available through Illinois Central Management Services (CMS) website:
https://cms.illinois.gov/personnel/employeeresources/personnellaborrelations.html
IP rates effective 10/1/2023:
IP $17.25
CNA $20.25
LPN $27.25
RN $34.00

IL.0202.R07.02 effective 8/1/2024, IP rate increases in accordance with the SEIU Collective Bargaining Agreement: IP $17.75, CNA $20.75, LPN $27.75, RN $34.50.

IL.0202.R07.03 effective 01/01/2025, IP and IP Respite rate increases in accordance with the SEIU Collective Bargaining Agreement: IP: $18.25, CNA: $21.25, LPN: $28.25, RN: $35.00.

IL.0202.R07.04 effective 07/01/2025, or upon CMS approval, IP and IP Respite rate increases in accordance with the SEIU Collective Bargaining Agreement:
IP: $18.75, CNA: $21.75, LPN: $28.75, RN: $35.50.

Home Health Extended State Plan and "Other" Services:
This includes In-Home Shift Nursing, RNs, LPNs, intermittent nurse visits, CNAs, Home Health Aides (HHA), OT, PT, and ST. Rates for State Plan services are reviewed minimally every five (5) years to ensure rates are adequate to maintain an ample provider base, quality of service, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program.

Different rates are paid for RNs, LPNs, and CNAs/HHAs depending on if the service is provided by a licensed HHA or an independent licensed or certified provider. Historically, the independent licensed or certified provider rates were negotiated on an individual customer basis, with rate ceilings based on prevailing wage rates for these providers statewide. In July 2012, the SEIU contract was expanded to include independent licensed or certified providers, using a fixed rate schedule for each type of service. These rates are available to the public through the Illinois CMS 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 2017 and set in 2018. The rates for agency-based providers are not geographically based and do not include room and board. The State reviewed the rate 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. The rate

for agency based CNAs/HHAs was last reviewed and set in 2023. CNA/HHA rates are not geographically based and do not include room and board.

Agency based provider rates effective 10/1/2023:
RN: $45.00
LPN: $37.50
HHA/CNA: $25.00
Intermittent Nursing Visit: $111.00
These rates are based upon the Home Health Fee Schedule effective 11/1/2019 and updated 2/4/2020.
https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/homehealthfeescheduleeffective11012019revised020420

Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST):
State Plan services are reviewed minimally every five (5) years to ensure rates are adequate to maintain an ample provider base, quality of service, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. Therapy rates are not geographically based and do not include room and board. The State completed a review of the OT, PT, and ST rates in 2021. These rates are based upon the Home Health Fee Schedule effective 11/1/2019 and updated 2/4/2020.
https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/homehealthfeescheduleeffective11012019revised020420

OT, PT, ST rates effective 10/1/2023: $111.00

Homemaker:
The homemaker and respite homemaker rate is a fixed unit rate based on the rates established by the IDoA in the Persons who are Elderly waiver (IL.0143). Homemaker providers are required to expend a minimum of 77% of total revenues on direct service worker costs. The remaining 23% of revenues may be spent by provider agencies at their discretion on administrative or program support costs (See 89 Ill. Adm. Code Section 240.2040). Expenses that may be counted as direct service worker costs include wages, health coverage, retirement, Federal Insurance Contributions Act (FICA), uniforms, workers compensation, travel reimbursement, Federal Unemployment Tax Act (FUTA), and unemployment insurance. Program supports 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 Ill. Adm. Code Section 240.2050. The homemaker rate includes admin 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 (5) years to ensure rates are adequate to maintain an ample provider base, quality of service, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. The rate was last reviewed in 2023 and increased 4/1/2023.

Homemaker rate effective 10/1/2023: $26.92

Amendment IL.0202.R07.01 increased the Homemaker rate and the Respite Homemaker Rate effective 01/01/2024 to $28.07

Amendment IL.0202.R07.03, effective 01/01/2025.
Increase the Homemaker and Respite Homemaker rates from $28.07 to $29.63 in response to Public Act 103-0588. The base rates are increasing to $29.63 per hour/unit. The rates in Appendix J-2-d reflects a blend of the base rate and the enhanced insurance rate of $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.

Adult Day Service (ADS):
ADS rates are based on rates established by established by the IDoA in the Persons who are Elderly waiver (IL.0143). ADS providers in this waiver are the same as used by IDoA. Staffing ratios and staff qualifications are the same as ADS providers used by 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. Rates are not geographically based and do not include room and board. ADS rates are reviewed minimally every five (5) years by IDoA to ensure the rates are adequate to maintain an ample provider base, quality of service, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. The ADS

and ADST rates were set in 2019 following a rate study completed in 2018. The study was conducted by an external vendor to ensure rates are efficient, cost effective, and allow for the purchase of services at the lowest rate to 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 that included customers, reviewing existing state data, and developing and distributing 2 provider surveys. The State plans to review ADS and ADST rates before the end of calendar year 2023.

ADS rate effective 10/1/2023: $15.30
ADST rate effective 10/1/2023: $11.29 per trip

Amendment IL.0202.R07.01 increased the ADS rate and the Respite ADS Rate to $16.84 and the ADST rate and the Respite ADST rate to $12.44 effective 01/01/2024.

Personal Emergency Response System (PERS):
PERS rates are based on the rates established the IDoA in the Persons who are Elderly waiver (IL.0143). 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 (5) 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 last increased in 2019. The IDoA completed a review of the PERS rate in 2023.

PERS installation rate effective 10/1/2023: $40.00
PERS monthly rate effective 10/1/2023: $28.00

Home Delivered Meals (HDM):
The HDM rate is standardized and based on rates set under Title III of the Older Americans Act. The Ill. Admin. Code 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 admin. costs. The rate is subject to Cost of Living Adjustment (COLA) when enacted and published on the OA's website under HSP. The HDM rate was reviewed in 2023. The State will perform a rate review to ensure the rates are adequate. In the future, the HDM rate will be reviewed minimally every five (5) years.

HDM rate effective 10/1/2023: $15.00

IL.0202.R07.02 increased HDM rates in response to increased food and labor costs; HDM rate effective 08/01/2024: $16.00 per 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.

CONTINUED under 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 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. The provider can choose to receive payment directly from the MA.

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 or OA Case Manager 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 of 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 FFP.

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 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

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 Providers (IPs) 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 IPs to verify that services were performed in accordance with the PCP. 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. Currently, the OA requires both paper timesheets and EVV. The OA is working towards eliminating timesheets and using EVV exclusively. OA local office staff verify that 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 are 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, the OA Case Managers, 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 reduce the state's claim for FFP through an adjustment process. If the correction includes a recoupment, the collection occurs through future billings submitted by the provider until the money is recouped. 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 is 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.

Amendment IL.0202.R07.01 - effective 1/1/2024
Personal care services are subject to electronic visit verification (EVV). Methods for EVV are a mobile app and telephony from a landline.

The OA's EVV Non-Compliance Policy requires mandatory use of EVV and IPs to use the mobile app or the customer's registered EVV landline or cell phone to call in and out of the EVV Telephony system to report daily work hours. An IP is considered non-compliant if either one or more, and/or a combination of the following occurs during a single pay-period:
1. No EVV visits are recorded in the Portal (IP is not using EVV to clock in/out)
2. Have five or more visits that are missing from the portal (IP did not call in/out on one or more occasions).
3. Have five or more visits on the timesheet that DO NOT match call times in the Portal by 10 minutes.
4. Have five or more visits from a non-registered EVV telephone number.
5. Have five or more visits in the Portal where data was added/edited.

If one or more, and/or a combination of the above occurs during a single pay-period, the HSP Coordinator will verbally remind the Customer that that EVV is mandatory and it is his/her responsibility to manage the IP's time, and failure to comply with EVV may result in delayed paychecks and IPs being replaced with agency provider(s). If a 2nd incidence of non-compliance occurs, the HSP Coordinator will inform the customer verbally and in writing that, if the IP continues to not comply with EVV, the IP will be removed and replaced with agency provider(s). If a 3rd incidence of non-compliance

occurs, the HSP Counselor will inform customer that the IP(s) will be replaced with an agency provider(s).

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. Providers may bill the MA directly.

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 MA pays providers of some or all waiver services through the use of a 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 agrees to allow 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, which is 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 review. Claims that pass through the system without error filter down to the Management Administrative Reporting System (MARS). The MARS system is responsible for generating the reports to the MA's 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 which program the expenditure should be reported. The BFF report the expenditures on the CMS 64 on a quarterly basis thirty (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.

Not applicable.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are*

made. Select one:

- ○ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ◉ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

The only service that has 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.

The Operating Agency (OA), Department of Human Services- Division of Rehabilitation Services (DHS-DRS)

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have

free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ◉ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The OA receives the non-federal share through 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	22143.96	12275.28	34419.24	69147.21	12929.73	82076.94	47657.70
2	23489.78	13031.44	36521.22	73575.20	13643.32	87218.52	50697.30
3	25220.49	13834.44	39054.93	78287.68	14399.03	92686.71	53631.78
4	27089.33	14687.19	41776.52	83302.96	15199.57	98502.53	56726.01
5	29181.92	15592.79	44774.71	88640.57	16047.86	104688.43	59913.72

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	1263	1263
Year 2	1263	1263
Year 3	1263	1263
Year 4	1263	1263
Year 5	1263	1263

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay (ALOS) estimate for each waiver year is equal to the projected total number of days participants will be enrolled in the waiver divided by the unduplicated participant count. The ALOS has been projected based upon waiver enrollment from July 2020 through June 2022 in the State's Medicaid Management Information System (MMIS) system. Enrollment data after June 2022 was not considered due to data quality concerns.

Amendment IL.0202.R07.01 - effective 1/1/2024
WY 1 and WY 5 contain leap days. The ALOS WY 1 and WY 5 is one day greater (339 days) as compared to 338 days in WYs 2, 3, and 4.

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 for the five-year waiver cycle was projected in the following manner:

Unduplicated users for each waiver service: In the development of this waiver renewal, instead of relying on the approved 372(S) reports, estimates were developed using CY 2021 and CY 2022 claims and enrollment data in the State's MMIS system. Users, units, and paid amounts were summarized by each waiver service separately for each waiver year and by managed care and FFS customers. These summaries are similar to the approved 372(S) reports, except runout is through February 2023 for MMIS claims rather than eighteen (18) months, and values are stratified by managed care and FFS.

Factor D is the annual per capita cost for waiver services for waiver customers. Factor D estimates for each waiver year are the sum of expenditures for each waiver service divided by the total number of unduplicated waiver customers for the waiver year. The expenditures for each waiver service are the product of the number of unduplicated users, average units per user, and the average cost per unit.

Unduplicated users for each waiver service: Unduplicated users for each waiver service were estimated by multiplying the percent of total unduplicated customers receiving each waiver service by the total unduplicated customer count for each waiver year. The percent of total unduplicated participants receiving each waiver service were based upon historical experience in MMIS under the current waiver during calendar year 2021 (base period). Waiver services not utilized in the base period were assumed to have ten (10) users per waiver year period.

Average units per user: The average units per user for each waiver service was based upon historical experience for customers enrolled in the waiver during the base period. Waiver services not utilized in the base period were assumed to have one (1) unit per user. Amounts for waiver years two (2) through five (5) were calculated by multiplying the prior year average units per user by the change in ALOS between waiver years. WY 1 and WY 5 have slightly higher units per user because of the extra day attributable to leap years.

Average cost per unit: For services without a fee schedule (Environmental Accessibility Modifications and Specialized Medical Equipment), the average cost per unit was developed using calendar year 2022 experience trended to the midpoint of each waiver year. For all other services, the average cost per unit was developed with the assumed April 1, 2023, fee schedule (https://www.dhs.state.il.us/page.aspx?item=83520) trended to the midpoint of each waiver year. Trend assumptions differed by waiver service:

-Adult Day Service, Adult Day Service Transportation, Homemaker, Personal Assistant, Individual Provider (RN, LPN, CNA) trends were calculated as the annualized reimbursement change between March 1, 2020 and March 1, 2023.

-Respite service trends were set equal to their non-respite counterparts. The average cost per unit was developed with the assumed April 1, 2023, fee schedule (https://www.dhs.state.il.us/page.aspx?item=83520) trended to the midpoint of each waiver year.

-Agency provider (RN, LPN, CNA) trends were set equal to their independent counterparts. The average cost per unit was developed with the assumed April 1, 2023, fee schedule (https://www.dhs.state.il.us/page.aspx?item=83520) trended to the midpoint of each waiver year.

-Environmental Accessibility Adaptations, Specialized Medical Equipment, and Personal Emergency Response Systems Monthly Monitoring and Install trends were assumed to be 3.5%, consistent with the annualized change in the Consumer Price Index (CPI) for Medical Equipment and Supplies between January 2021 and January 2023 (https://beta.bls.gov/dataViewer/view/timeseries/PCU33911-33911-).

Home Delivered Meals trends were assumed to be 7.5%, consistent with food price outlook forecasts from the U.S. Department of Agriculture (https://www.ers.usda.gov/data-products/food-price-outlook/summary-findings/).

-Occupational, Physical, and Speech Therapy trends were assumed to be 3.0%, consistent with the cost portion of Factor D trends because they are similar to State plan services. The average cost per unit was developed with the assumed April 1, 2023, fee schedule (https://www.dhs.state.il.us/page.aspx?item=83520) trended to the midpoint of each waiver year.

-Intermittent Nursing and Multi-Customer Nursing trends were set to equal to Independent RN Shift Nursing Trends. The average cost per unit was developed with the assumed April 1, 2023, fee schedule (https://www.dhs.state.il.us/page.aspx?item=83520) trended to the midpoint of each waiver year.

Amendment IL.0202.R07.01 - effective 1/1/2024
The State originally estimated cost per service for the waiver renewal without knowing what actual fee schedules would be effective during WY 1. Between the renewal and the amendment, the MA received actual fee schedules effective January 2024. Because we were already amending for homemaker, ADS and ADST costs, we amended cost per service for most services to the known fee schedules. Our original estimates in the waiver renewal for WY 1 were generally higher than the since-established fee schedules, so we revised cost per service downward to reflect the actual fee schedules in this amendment.

The average cost per unit was updated for Homemaker, Respite Homemaker, Adult Day Service, Respite Adult Day Service, Adult Day Service Transportation, and Respite Adult Day Service Transportation effective 1/1/2024 in response to legislation passed by the Illinois General Assembly Medicaid Omnibus bill, SB1298. 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. Reimbursement for all other services not listed above were updated to be consistent with rates being paid for the current waiver year. We updated future waiver year cost per service amounts by applying trends from the original waiver filing to the known WY 1 experience.
Homemaker and Respite Homemaker: 01/01/24: $28.07
Adult Day Service and Respite Adult Day Service: 01/01/24: $16.84
Adult Day Service Transportation and Respite Adult Day Service Transportation: 01/01/24: $12.44 per trip

The number of units per user for Adult Day Service, Adult Day Service Transportation, Homemaker, Homemaker FFS, Individual Provider, Home Health Aide Non-Agency (CNA), Home Health Aide Non-Agency (CNA)-FFS, Home Delivered Meals, Home Delivered Meals-FFS, In-Home Shift Nursing-LPN Non-Agency, Personal Emergency Response (Monthly Monitoring), and Personal Emergency Response (Monthly Monitoring)-FFS are increased in WY 1 and WY 5 due to leap days. The leap days make the ALOS is one day longer (339 days) compared to 338 days in WYs 2, 3, and 4. A slight increase in the number of units is expected given the longer ALOS.

Amendment IL.0202.R07.02, effective 8/1/2024
The average cost per unit was updated for Individual Provider services (IPs) effective 8/1/2024 in response to the SEIU Collective Bargaining Unit Agreement. Respite rates for IPs also apply 08/01/2024, or upon CMS approval: IP: $17.75, IP (CNA): $20.75, IP (LPN): $27.75; IP (RN): $34.50

Amendment IL.0202.R07.03, effective 01/01/2025:
The average cost per unit was updated for Individual Provider services (IPs) in response to the SEIU Collective Bargaining Unit Agreement. Respite rates for IPs also apply: IP: $18.25, IP (CNA): $21.25, IP (LPN): $28.25; IP (RN): $35.00.

Homemaker and Respite Homemaker rates will increase from $28.07 to $29.63 in response to Public Act 103-0588.

Amendment IL.0202.R07.04, effective 07/01/2025, or upon CMS approval:

The average cost per unit was updated for Individual Provider services (IPs) in response to the SEIU Collective Bargaining Unit Agreement. Respite rates for IPs also apply:

IP: $18.75, IP (CNA): $21.75, IP (LPN): $28.75; IP (RN): $35.50.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

In the development of this waiver renewal, previously approved 372(S) reports were not used as a basis because most waiver enrollees are in managed care. Estimates were developed using CY 2023 HealthChoice and MMAI capitation rates along with CY 2021 and CY 2022 claims and enrollment data in the State's MMIS system for enrollees ineligible for managed care.

For customers eligible for managed care, CY 2023 per member per month (PMPM) benefit expenses for non-waiver services reflected in the CY 2023 HealthChoice and MMAI capitation rates for Other Waiver rate cells were used for base benefit expenses. Costs for non-waiver services not covered in the capitation rates which were estimated during CY 2023 capitation rate development were added. An acuity adjustment of approximately 2.534 was applied to the Disabled Adult (DA)—Other Waiver rate cell to reflect higher PMPM costs for HIV waiver enrollees relative to the average member month in the DA—Other Waiver rate cell, primarily driven by retail pharmacy costs.

For enrollees ineligible for managed care, CY 2021 non-waiver expenditures for Medicaid enrollees with an open HIV Waiver segment in MMIS were summarized and divided by the applicable member months to develop a non-waiver PMPM base benefit expense.

To estimate Factor D', non-waiver PMPM base benefit expenses were trended from the midpoint of the base experience period to the midpoint of each waiver year. Trend assumptions of approximately 6.2% were sourced from CY 2023 capitation rate development for Other Waiver rate cells. PMPMs were composited across rate cells and customers ineligible for managed care using June 2022 HIV Waiver enrollment distribution. They were also annualized for each waiver year using projected ALOS.

Factors are causing Factor G' to be greater than Factor D' are attributed to the observed historic experience within those populations. We've observed slightly higher Prime costs for customers in a nursing facility than customers in a waiver. Factor D' and Factor G' estimated costs were based on underlying CY2021 FFS and MCO base experience trended and adjusted to the waiver period.

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:*

For customers eligible for managed care, CY 2023 PMPM benefit expenses for institutional services reflected in the CY 2023 HealthChoice and MMAI capitation rates for Nursing Facility rate cells were used for base benefit expenses. For enrollees ineligible for managed care, CY 2021 institutional expenditures for Medicaid enrollees in MMIS with a prior HIV diagnosis and institutionalized in a nursing facility for that month were summarized and divided by the applicable member months to develop an institutionalized PMPM base benefit expense.

To estimate Factor G, institutional PMPM base benefit expenses were trended from the midpoint of the base experience period to the midpoint of each waiver year. Trend assumptions of approximately 6.4% were sourced from CY 2023 capitation rate development for Nursing Facility rate cells. PMPMs were composited across rate cells and enrollees ineligible for managed care using the June 2022 HIV Waiver enrollment distribution in MMIS. They were also annualized for each waiver year using projected ALOS.

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:*

For customers eligible for managed care, CY 2023 PMPM benefit expenses for non-institutional services reflected in the CY 2023 HealthChoice and MMAI capitation rates for Nursing Facility rate cells were used for base benefit expenses. Costs for non-institutional services not covered in the capitation rates which were estimated during CY 2023 capitation rate development were added.

For customers ineligible for managed care, Medicare eligibility has a substantial impact on the cost profile for non-institutional services. To be comparable to the Factor D' population, the institutionalized and waiver populations must contain the same mix of dual eligible and non-dual eligible customers.

Based on our review of the customers ineligible for managed care, the institutionalized population has a significantly smaller proportion of dual eligible customers than the waiver population and does not appropriately reflect the cost of non-institutional services for the waiver-eligible population absent the waiver. Instead, due to the inability to accurately differentiate dual versus non-dual eligible customers in the population ineligible for managed care, non-institutional base benefit for the customers ineligible for managed care for the Factor G' population were assumed to equal non-institutional base benefit expenses for the customers ineligible for managed care for the Factor D' population.

To estimate factor G prime, the non-institutional PMPM base benefit expenses were trended from the midpoint of the base experience period to the midpoint of each waiver year. Trend assumptions of approximately 5.5% were sourced from the calendar year 2023 capitation rate development for nursing facility rate cells. PMPM's were composited across rate cells and enrollees in eligible for managed care using June 2022 HIV waiver enrollment distribution in MMIS. They were also annualized for each waiver year using the projected ALOS.

Per page 289 of the technical guide, if Factor D' is less than Factor G', the state should provide an explanation of the reasons why. The cost difference between G' and D' can be attributed to the observed historic experience. Within these populations we have observed slightly higher prime cost for enrollees in a nursing facility than enrollees in a waiver.

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	
Intermittent Nursing	
Occupational Therapy	
Physical Therapy	
Speech Therapy	
Environmental Accessibility Adaptations	
Home Delivered Meals	
In-Home Shift Nursing	
Personal Emergency Response System	
Specialized Medical Equipment and Supplies	

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:							***130890.70***
Adult Day Service	☒	*Hour*	*10*	*598.87*	*16.45*	***98514.12***	
Adult Day Service - FFS	☐	*Hour*	*10*	*1.00*	*16.45*	***164.50***	
Adult Day Service Transportation	☒	*Trip*	*10*	*264.12*	*12.15*	***32090.58***	
Adult Day Service Transportation - FFS	☐	*Trip*	*10*	*1.00*	*12.15*	***121.50***	
Homemaker Total:							***3423354.92***
Homemaker	☒	*Hour*	*157*	*567.46*	*29.11*	***2593445.41***	
Homemaker - FFS	☐	*Hour*	*43*	*663.01*	*29.11*	***829909.51***	
Individual Provider Total:							***23574293.92***
Individual Provider	☒	*Hour*	*780*	*1298.25*	*18.57*	***18804631.95***	
Individual Provider - FFS	☐	*Hour*	*259*	*991.69*	*18.57*	***4769661.97***	
Respite Total:							***3280.20***
Respite RN	☒	*Hour*	*10*	*1.00*	*36.60*	***366.00***	
Respite RN - FFS	☐	*Hour*	*10*	*1.00*	*36.60*	***366.00***	
Respite LPN	☒	*Hour*	*10*	*1.00*	*29.33*	***293.30***	
Respite LPN - FFS	☐	*Hour*	*10*	*1.00*	*29.33*	***293.30***	
Respite Homemaker	☒	*Hour*	*10*	*1.00*	*29.11*	***291.10***	

GRAND TOTAL:	***27967815.22***
Total: Services included in capitation:	*22155998.34*
Total: Services not included in capitation:	*5811816.88*
Total Estimated Unduplicated Participants:	***1263***
Factor D (Divide total by number of participants):	***22143.96***
Services included in capitation:	*17542.36*
Services not included in capitation:	*4601.60*
Average Length of Stay on the Waiver:	*339*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Homemaker - FFS	☐	Hour	10	1.00	29.11	291.10	
Respite Individual Provider	☒	Hour	10	1.00	18.57	185.70	
Respite Individual Provider - FFS	☐	Hour	10	1.00	18.57	185.70	
Respite Adult Day Service	☒	Hour	10	1.00	16.45	164.50	
Respite Adult Day Service - FFS	☐	Hour	10	1.00	16.45	164.50	
Respite Adult Day Service Transportation	☒	Trip	10	1.00	12.15	121.50	
Respite Adult Day Service Transportation - FFS	☐	Trip	10	1.00	12.15	121.50	
Respite Home Health Aide (CNA)	☒	Hour	10	1.00	21.80	218.00	
Respite Home Health Aide (CNA) - FFS	☐	Hour	10	1.00	21.80	218.00	
Home Health Aide Total:							187528.74
Home Health Aide Agency (CNA)	☒	Hour	10	1.00	25.00	250.00	
Home Health Aide Agency (CNA) - FFS	☐	Hour	10	1.00	25.00	250.00	
Home Health Aide Non-Agency (CNA)	☒	Hour	10	440.21	21.80	95965.78	
Home Health Aide Non-Agency (CNA) - FFS	☐	Hour	10	417.72	21.80	91062.96	
Intermittent Nursing Total:							2220.00
Intermittent Nursing	☒	Visit	10	1.00	111.00	1110.00	
Intermittent Nursing - FFS	☐	Visit	10	1.00	111.00	1110.00	
Occupational Therapy Total:							4440.00
Occupational Therapy Over	☒	Hour	10	1.00	111.00	1110.00	

GRAND TOTAL:	27967815.22
Total: Services included in capitation:	22155998.34
Total: Services not included in capitation:	5811816.88
Total Estimated Unduplicated Participants:	1263
Factor D (Divide total by number of participants):	22143.96
Services included in capitation:	17542.36
Services not included in capitation:	4601.60
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Age 18							
Occupational Therapy Over Age 18 -FFS	☐	Hour	10	1.00	111.00	1110.00	
Occupational Therapy Under Age 18	☒	Hour	10	1.00	111.00	1110.00	
Occupational Therapy Under Age 18-FFS	☐	Hour	10	1.00	111.00	1110.00	
Physical Therapy Total:							4440.00
Physical Therapy Over Age 18	☒	Hour	10	1.00	111.00	1110.00	
Physical Therapy Over Age 18 FFS	☐	Hour	10	1.00	111.00	1110.00	
Physical Therapy Under Age 18	☒	Hour	10	1.00	111.00	1110.00	
Physical Therapy Under Age 18 - FFS	☐	Hour	10	1.00	111.00	1110.00	
Speech Therapy Total:							4440.00
Speech Therapy Over Age 18	☒	Hour	10	1.00	111.00	1110.00	
Speech Therapy Over Age 18 -FFS	☐	Hour	10	1.00	111.00	1110.00	
Speech Therapy Under Age 18	☒	Hour	10	1.00	111.00	1110.00	
Speech Therapy Under Age 18 - FFS	☐	Hour	10	1.00	111.00	1110.00	
Environmental Accessibility Adaptations Total:							150179.00
Environmental Accessibility Adaptations	☒	Unit	10	1.00	7508.95	75089.50	
Environmental Accessibility Adaptations - FFS	☐	Unit	10	1.00	7508.95	75089.50	
Home Delivered Meals Total:							352941.00

GRAND TOTAL:	27967815.22
Total: Services included in capitation:	22155998.34
Total: Services not included in capitation:	5811816.88
Total Estimated Unduplicated Participants:	1263
Factor D (Divide total by number of participants):	22143.96
Services included in capitation:	17542.36
Services not included in capitation:	4601.60
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals	☒	Day	134	168.25	15.00	338182.50	
Home Delivered Meals - FFS	☐	Day	10	98.39	15.00	14758.50	
In-Home Shift Nursing Total:							44062.86
RN Agency	☒	Hour	10	1.00	45.00	450.00	
RN Agency - FFS	☐	Hour	10	1.00	45.00	450.00	
RN Non-Agency	☒	Hour	10	1.00	36.60	366.00	
RN Non-Agency -FFS	☐	Hour	10	1.00	36.60	366.00	
LPN Agency	☒	Hour	10	1.00	37.50	375.00	
LPN Agency - FFS	☐	Hour	10	1.00	37.50	375.00	
LPN Non-Agency	☒	Hour	10	141.11	29.33	41387.56	
LPN Non-Agency - FFS	☐	Hour	10	1.00	29.33	293.30	
Personal Emergency Response System Total:							56492.68
Personal Emergency Response (Monthly Monitoring)	☒	Month	204	8.77	28.00	50094.24	
Personal Emergency Response (Monthly Monitoring) - FFS	☐	Month	19	9.17	28.00	4878.44	
Personal Emergency Response (Install)	☒	Unit	28	1.00	40.00	1120.00	
Personal Emergency Response (Install) - FFS	☐	Unit	10	1.00	40.00	400.00	
Specialized Medical Equipment and Supplies Total:							29251.20

GRAND TOTAL:	27967815.22
Total: Services included in capitation:	22155998.34
Total: Services not included in capitation:	5811816.88
Total Estimated Unduplicated Participants:	1263
Factor D (Divide total by number of participants):	22143.96
Services included in capitation:	17542.36
Services not included in capitation:	4601.60
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment	☒	Unit	10	1.00	1462.56	14625.60	
Specialized Medical Equipment - FFS	☐	Unit	10	1.00	1462.56	14625.60	

GRAND TOTAL:	**27967815.22**
Total: Services included in capitation:	22155998.34
Total: Services not included in capitation:	5811816.88
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**22143.96**
Services included in capitation:	17542.36
Services not included in capitation:	4601.60
Average Length of Stay on the Waiver:	339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**133603.94**
Adult Day Service	☒	Hour	10	597.10	16.84	100551.64	
Adult Day Service - FFS	☐	Hour	10	1.00	16.84	168.40	
Adult Day Service Transportation	☒	Trip	10	263.34	12.44	32759.50	
Adult Day Service Transportation - FFS	☐	Trip	10	1.00	12.44	124.40	
Homemaker Total:							**3447272.89**
Homemaker	☒	Hour	157	565.79	29.40	2611573.48	

GRAND TOTAL:	**29667590.56**
Total: Services included in capitation:	23510958.97
Total: Services not included in capitation:	6156631.59
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**23489.78**
Services included in capitation:	18615.17
Services not included in capitation:	4874.61
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker - FFS	☐	Hour	43	661.05	29.40	835699.41	
Individual Provider Total:							25200812.52
Individual Provider	☒	Hour	780	1294.42	19.91	20102083.72	
Individual Provider - FFS	☐	Hour	259	988.76	19.91	5098728.80	
Respite Total:							3403.00
Respite RN	☒	Hour	10	1.00	37.85	378.50	
Respite RN - FFS	☐	Hour	10	1.00	37.85	378.50	
Respite LPN	☒	Hour	10	1.00	30.60	306.00	
Respite LPN - FFS	☐	Hour	10	1.00	30.60	306.00	
Respite Homemaker	☒	Hour	10	1.00	29.40	294.00	
Respite Homemaker - FFS	☐	Hour	10	1.00	29.40	294.00	
Respite Individual Provider	☒	Hour	10	1.00	19.91	199.10	
Respite Individual Provider - FFS	☐	Hour	10	1.00	19.91	199.10	
Respite Adult Day Service	☒	Hour	10	1.00	16.84	168.40	
Respite Adult Day Service - FFS	☐	Hour	10	1.00	16.84	168.40	
Respite Adult Day Service Transportation	☒	Trip	10	1.00	12.44	124.40	
Respite Adult Day Service Transportation - FFS	☐	Trip	10	1.00	12.44	124.40	
Respite Home Health Aide (CNA)	☒	Hour	10	1.00	23.11	231.10	
Respite Home Health Aide (CNA) - FFS	☐	Hour	10	1.00	23.11	231.10	
Home Health Aide Total:							198212.94

GRAND TOTAL:	**29667590.56**
Total: Services included in capitation:	23510958.97
Total: Services not included in capitation:	6156631.59
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**23489.78**
Services included in capitation:	18615.17
Services not included in capitation:	4874.61
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Health Aide Agency (CNA)	☒	Hour	10	1.00	26.50	265.00	
Home Health Aide Agency (CNA) - FFS	☐	Hour	10	1.00	26.50	265.00	
Home Health Aide Non-Agency (CNA)	☒	Hour	10	438.91	23.11	101432.10	
Home Health Aide Non-Agency (CNA) - FFS	☐	Hour	10	416.49	23.11	96250.84	
Intermittent Nursing Total:							2295.60
Intermittent Nursing	☒	Visit	10	1.00	114.78	1147.80	
Intermittent Nursing - FFS	☐	Visit	10	1.00	114.78	1147.80	
Occupational Therapy Total:							4573.20
Occupational Therapy Over Age 18	☒	Hour	10	1.00	114.33	1143.30	
Occupational Therapy Over Age 18 -FFS	☐	Hour	10	1.00	114.33	1143.30	
Occupational Therapy Under Age 18	☒	Hour	10	1.00	114.33	1143.30	
Occupational Therapy Under Age 18-FFS	☐	Hour	10	1.00	114.33	1143.30	
Physical Therapy Total:							4573.20
Physical Therapy Over Age 18	☒	Hour	10	1.00	114.33	1143.30	
Physical Therapy Over Age 18 FFS	☐	Hour	10	1.00	114.33	1143.30	
Physical Therapy Under Age 18	☒	Hour	10	1.00	114.33	1143.30	
Physical Therapy Under Age 18 - FFS	☐	Hour	10	1.00	114.33	1143.30	
Speech Therapy Total:							4573.20
Speech Therapy Over Age 18	☒	Hour	10	1.00	114.33	1143.30	

GRAND TOTAL:	**29667590.56**
Total: Services included in capitation:	23510958.97
Total: Services not included in capitation:	6156631.59
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**23489.78**
Services included in capitation:	18615.17
Services not included in capitation:	4874.61
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy Over Age 18 -FFS	☐	Hour	10	1.00	114.33	1143.30	
Speech Therapy Under Age 18	☒	Hour	10	1.00	114.33	1143.30	
Speech Therapy Under Age 18 - FFS	☐	Hour	10	1.00	114.33	1143.30	
Environmental Accessibility Adaptations Total:							155464.60
Environmental Accessibility Adaptations	☒	Unit	10	1.00	7773.23	77732.30	
Environmental Accessibility Adaptations - FFS	☐	Unit	10	1.00	7773.23	77732.30	
Home Delivered Meals Total:							378401.74
Home Delivered Meals	☒	Day	134	167.75	16.13	362578.20	
Home Delivered Meals - FFS	☐	Day	10	98.10	16.13	15823.53	
In-Home Shift Nursing Total:							45827.14
RN Agency	☒	Hour	10	1.00	46.53	465.30	
RN Agency - FFS	☐	Hour	10	1.00	46.53	465.30	
RN Non-Agency	☒	Hour	10	1.00	37.85	378.50	
RN Non-Agency -FFS	☐	Hour	10	1.00	37.85	378.50	
LPN Agency	☒	Hour	10	1.00	39.12	391.20	
LPN Agency - FFS	☐	Hour	10	1.00	39.12	391.20	
LPN Non-Agency	☒	Hour	10	140.69	30.60	43051.14	
LPN Non-Agency - FFS	☐	Hour	10	1.00	30.60	306.00	
Personal Emergency Response System Total:							58295.99

GRAND TOTAL:	**29667590.56**
Total: Services included in capitation:	23510958.97
Total: Services not included in capitation:	6156631.59
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**23489.78**
Services included in capitation:	18615.17
Services not included in capitation:	4874.61
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response (Monthly Monitoring)	☒	Month	204	8.74	28.99	51688.01	
Personal Emergency Response (Monthly Monitoring) - FFS	☐	Month	19	9.14	28.99	5034.40	
Personal Emergency Response (Install)	☒	Unit	28	1.00	41.41	1159.48	
Personal Emergency Response (Install) - FFS	☐	Unit	10	1.00	41.41	414.10	
Specialized Medical Equipment and Supplies Total:							30280.60
Specialized Medical Equipment	☒	Unit	10	1.00	1514.03	15140.30	
Specialized Medical Equipment - FFS	☐	Unit	10	1.00	1514.03	15140.30	

GRAND TOTAL:	**29667590.56**
Total: Services included in capitation:	23510958.97
Total: Services not included in capitation:	6156631.59
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**23489.78**
Services included in capitation:	18615.17
Services not included in capitation:	4874.61
Average Length of Stay on the Waiver:	338

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:							**136907.64**
Adult Day Service	☒	Hour	10	597.10	17.22	**102820.62**	
Adult Day Service - FFS	☐	Hour	10	1.00	17.22	**172.20**	
Adult Day Service Transportation	☒	Trip	10	263.34	12.83	**33786.52**	
Adult Day Service Transportation - FFS	☐	Trip	10	1.00	12.83	**128.30**	
Homemaker Total:							**3768549.35**
Homemaker	☒	Hour	157	565.79	32.14	**2854965.02**	
Homemaker - FFS	☐	Hour	43	661.05	32.14	**913584.32**	
Individual Provider Total:							**27010815.63**
Individual Provider	☒	Hour	780	1294.42	21.34	**21545879.78**	
Individual Provider - FFS	☐	Hour	259	988.76	21.34	**5464935.85**	
Respite Total:							**3582.00**
Respite RN	☒	Hour	10	1.00	39.14	**391.40**	
Respite RN - FFS	☐	Hour	10	1.00	39.14	**391.40**	
Respite LPN	☒	Hour	10	1.00	31.93	**319.30**	
Respite LPN - FFS	☐	Hour	10	1.00	31.93	**319.30**	
Respite Homemaker	☒	Hour	10	1.00	32.14	**321.40**	
Respite Homemaker - FFS	☐	Hour	10	1.00	32.14	**321.40**	
Respite Individual Provider	☒	Hour	10	1.00	21.34	**213.40**	
Respite Individual Provider - FFS	☐	Hour	10	1.00	21.34	**213.40**	
Respite Adult Day Service	☒					**172.20**	

GRAND TOTAL:	**31853480.20**
Total: Services included in capitation:	25241912.91
Total: Services not included in capitation:	6611567.28
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**25220.49**
Services included in capitation:	19985.68
Services not included in capitation:	5234.81
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Hour	10	1.00	17.22		
Respite Adult Day Service - FFS	☐	Hour	10	1.00	17.22	172.20	
Respite Adult Day Service Transportation	☒	Trip	10	1.00	12.83	128.30	
Respite Adult Day Service Transportation - FFS	☐	Trip	10	1.00	12.83	128.30	
Respite Home Health Aide (CNA)	☒	Hour	10	1.00	24.50	245.00	
Respite Home Health Aide (CNA) - FFS	☐	Hour	10	1.00	24.50	245.00	
Home Health Aide Total:							210134.80
Home Health Aide Agency (CNA)	☒	Hour	10	1.00	28.09	280.90	
Home Health Aide Agency (CNA) - FFS	☐	Hour	10	1.00	28.09	280.90	
Home Health Aide Non-Agency (CNA)	☒	Hour	10	438.91	24.50	107532.95	
Home Health Aide Non-Agency (CNA) - FFS	☐	Hour	10	416.49	24.50	102040.05	
Intermittent Nursing Total:							2373.80
Intermittent Nursing	☒	Visit	10	1.00	118.69	1186.90	
Intermittent Nursing - FFS	☐	Visit	10	1.00	118.69	1186.90	
Occupational Therapy Total:							4710.40
Occupational Therapy Over Age 18	☒	Hour	10	1.00	117.76	1177.60	
Occupational Therapy Over Age 18 -FFS	☐	Hour	10	1.00	117.76	1177.60	
Occupational Therapy Under Age 18	☒	Hour	10	1.00	117.76	1177.60	
Occupational Therapy Under Age 18-FFS	☐	Hour	10	1.00	117.76	1177.60	

GRAND TOTAL:	**31853480.20**
Total: Services included in capitation:	25241912.91
Total: Services not included in capitation:	6611567.28
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**25220.49**
Services included in capitation:	19985.68
Services not included in capitation:	5234.81
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy Total:							**4710.40**
Physical Therapy Over Age 18	☒	Hour	10	1.00	117.76	**1177.60**	
Physical Therapy Over Age 18 FFS	☐	Hour	10	1.00	117.76	**1177.60**	
Physical Therapy Under Age 18	☒	Hour	10	1.00	117.76	**1177.60**	
Physical Therapy Under Age 18 - FFS	☐	Hour	10	1.00	117.76	**1177.60**	
Speech Therapy Total:							**4710.40**
Speech Therapy Over Age 18	☒	Hour	10	1.00	117.76	**1177.60**	
Speech Therapy Over Age 18 -FFS	☐	Hour	10	1.00	117.76	**1177.60**	
Speech Therapy Under Age 18	☒	Hour	10	1.00	117.76	**1177.60**	
Speech Therapy Under Age 18 - FFS	☐	Hour	10	1.00	117.76	**1177.60**	
Environmental Accessibility Adaptations Total:							**160936.00**
Environmental Accessibility Adaptations	☒	Unit	10	1.00	8046.80	**80468.00**	
Environmental Accessibility Adaptations - FFS	☐	Unit	10	1.00	8046.80	**80468.00**	
Home Delivered Meals Total:							**406553.14**
Home Delivered Meals	☒	Day	134	167.75	17.33	**389552.40**	
Home Delivered Meals - FFS	☐	Day	10	98.10	17.33	**17000.73**	
In-Home Shift Nursing Total:							**47803.02**
RN Agency	☒	Hour	10	1.00	48.12	**481.20**	
RN Agency -	☐					**481.20**	

GRAND TOTAL:	**31853480.20**
Total: Services included in capitation:	25241912.91
Total: Services not included in capitation:	6611567.28
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**25220.49**
Services included in capitation:	19985.68
Services not included in capitation:	5234.81
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS		Hour	10	1.00	48.12		
RN Non-Agency	☒	Hour	10	1.00	39.14	**391.40**	
RN Non-Agency -FFS	☐	Hour	10	1.00	39.14	**391.40**	
LPN Agency	☒	Hour	10	1.00	40.81	**408.10**	
LPN Agency - FFS	☐	Hour	10	1.00	40.81	**408.10**	
LPN Non-Agency	☒	Hour	10	140.69	31.93	**44922.32**	
LPN Non-Agency - FFS	☐	Hour	10	1.00	31.93	**319.30**	
Personal Emergency Response System Total:							**60347.23**
Personal Emergency Response (Monthly Monitoring)	☒	Month	204	8.74	30.01	**53506.63**	
Personal Emergency Response (Monthly Monitoring) - FFS	☐	Month	19	9.14	30.01	**5211.54**	
Personal Emergency Response (Install)	☒	Unit	28	1.00	42.87	**1200.36**	
Personal Emergency Response (Install) - FFS	☐	Unit	10	1.00	42.87	**428.70**	
Specialized Medical Equipment and Supplies Total:							**31346.40**
Specialized Medical Equipment	☒	Unit	10	1.00	1567.32	**15673.20**	
Specialized Medical Equipment - FFS	☐	Unit	10	1.00	1567.32	**15673.20**	

GRAND TOTAL:	**31853480.20**
Total: Services included in capitation:	25241912.91
Total: Services not included in capitation:	6611567.28
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**25220.49**
Services included in capitation:	19985.68
Services not included in capitation:	5234.81
Average Length of Stay on the Waiver:	338

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:							**140357.40**
Adult Day Service	☒	Hour	10	597.10	17.62	**105209.02**	
Adult Day Service - FFS	☐	Hour	10	1.00	17.62	**176.20**	
Adult Day Service Transportation	☒	Trip	10	263.34	13.23	**34839.88**	
Adult Day Service Transportation - FFS	☐	Trip	10	1.00	13.23	**132.30**	
Homemaker Total:							**4121484.43**
Homemaker	☒	Hour	157	565.79	35.15	**3122340.40**	
Homemaker - FFS	☐	Hour	43	661.05	35.15	**999144.02**	
Individual Provider Total:							**28960049.75**
Individual Provider	☒	Hour	780	1294.42	22.88	**23100737.09**	
Individual Provider - FFS	☐	Hour	259	988.76	22.88	**5859312.66**	
Respite Total:							**3772.60**
Respite RN	☒	Hour	10	1.00	40.47	**404.70**	
Respite RN - FFS	☐	Hour	10	1.00	40.47	**404.70**	
Respite LPN	☒	Hour	10	1.00	33.31	**333.10**	
Respite LPN - FFS	☐	Hour	10	1.00	33.31	**333.10**	
Respite Homemaker	☒	Hour	10	1.00	35.15	**351.50**	

GRAND TOTAL:	**34213828.66**
Total: Services included in capitation:	27110912.51
Total: Services not included in capitation:	7102916.14
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**27089.33**
Services included in capitation:	21465.49
Services not included in capitation:	5623.84
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Homemaker - FFS	☐	Hour	10	1.00	35.15	351.50	
Respite Individual Provider	☒	Hour	10	1.00	22.88	228.80	
Respite Individual Provider - FFS	☐	Hour	10	1.00	22.88	228.80	
Respite Adult Day Service	☒	Hour	10	1.00	17.62	176.20	
Respite Adult Day Service - FFS	☐	Hour	10	1.00	17.62	176.20	
Respite Adult Day Service Transportation	☒	Trip	10	1.00	13.23	132.30	
Respite Adult Day Service Transportation - FFS	☐	Trip	10	1.00	13.23	132.30	
Respite Home Health Aide (CNA)	☒	Hour	10	1.00	25.97	259.70	
Respite Home Health Aide (CNA) - FFS	☐	Hour	10	1.00	25.97	259.70	
Home Health Aide Total:							222742.98
Home Health Aide Agency (CNA)	☒	Hour	10	1.00	29.78	297.80	
Home Health Aide Agency (CNA) - FFS	☐	Hour	10	1.00	29.78	297.80	
Home Health Aide Non-Agency (CNA)	☒	Hour	10	438.91	25.97	113984.93	
Home Health Aide Non-Agency (CNA) - FFS	☐	Hour	10	416.49	25.97	108162.45	
Intermittent Nursing Total:							2454.60
Intermittent Nursing	☒	Visit	10	1.00	122.73	1227.30	
Intermittent Nursing - FFS	☐	Visit	10	1.00	122.73	1227.30	
Occupational Therapy Total:							4851.60
Occupational Therapy Over	☒	Hour	10	1.00	121.29	1212.90	

GRAND TOTAL:	**34213828.66**
Total: Services included in capitation:	27110912.51
Total: Services not included in capitation:	7102916.14
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**27089.33**
Services included in capitation:	21465.49
Services not included in capitation:	5623.84
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Age 18							
Occupational Therapy Over Age 18 -FFS	☐	Hour	10	1.00	121.29	1212.90	
Occupational Therapy Under Age 18	☒	Hour	10	1.00	121.29	1212.90	
Occupational Therapy Under Age 18-FFS	☐	Hour	10	1.00	121.29	1212.90	
Physical Therapy Total:							4851.60
Physical Therapy Over Age 18	☒	Hour	10	1.00	121.29	1212.90	
Physical Therapy Over Age 18 FFS	☐	Hour	10	1.00	121.29	1212.90	
Physical Therapy Under Age 18	☒	Hour	10	1.00	121.29	1212.90	
Physical Therapy Under Age 18 - FFS	☐	Hour	10	1.00	121.29	1212.90	
Speech Therapy Total:							4851.60
Speech Therapy Over Age 18	☒	Hour	10	1.00	121.29	1212.90	
Speech Therapy Over Age 18 -FFS	☐	Hour	10	1.00	121.29	1212.90	
Speech Therapy Under Age 18	☒	Hour	10	1.00	121.29	1212.90	
Speech Therapy Under Age 18 - FFS	☐	Hour	10	1.00	121.29	1212.90	
Environmental Accessibility Adaptations Total:							166600.20
Environmental Accessibility Adaptations	☒	Unit	10	1.00	8330.01	83300.10	
Environmental Accessibility Adaptations - FFS	☐	Unit	10	1.00	8330.01	83300.10	
Home Delivered Meals Total:							437050.48

GRAND TOTAL:	**34213828.66**
Total: Services included in capitation:	27110912.51
Total: Services not included in capitation:	7102916.14
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**27089.33**
Services included in capitation:	21465.49
Services not included in capitation:	5623.84
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals	☒	Day	134	167.75	18.63	418774.46	
Home Delivered Meals - FFS	☐	Day	10	98.10	18.63	18276.03	
In-Home Shift Nursing Total:							49853.14
RN Agency	☒	Hour	10	1.00	49.76	497.60	
RN Agency - FFS	☐	Hour	10	1.00	49.76	497.60	
RN Non-Agency	☒	Hour	10	1.00	40.47	404.70	
RN Non-Agency -FFS	☐	Hour	10	1.00	40.47	404.70	
LPN Agency	☒	Hour	10	1.00	42.58	425.80	
LPN Agency - FFS	☐	Hour	10	1.00	42.58	425.80	
LPN Non-Agency	☒	Hour	10	140.69	33.31	46863.84	
LPN Non-Agency - FFS	☐	Hour	10	1.00	33.31	333.10	
Personal Emergency Response System Total:							62458.68
Personal Emergency Response (Monthly Monitoring)	☒	Month	204	8.74	31.06	55378.74	
Personal Emergency Response (Monthly Monitoring) - FFS	☐	Month	19	9.14	31.06	5393.88	
Personal Emergency Response (Install)	☒	Unit	28	1.00	44.37	1242.36	
Personal Emergency Response (Install) - FFS	☐	Unit	10	1.00	44.37	443.70	
Specialized Medical Equipment and Supplies Total:							32449.60

GRAND TOTAL:	**34213828.66**
Total: Services included in capitation:	27110912.51
Total: Services not included in capitation:	7102916.14
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**27089.33**
Services included in capitation:	21465.49
Services not included in capitation:	5623.84
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment	☒	Unit	10	1.00	1622.48	16224.80	
Specialized Medical Equipment - FFS	☐	Unit	10	1.00	1622.48	16224.80	

GRAND TOTAL:	**34213828.66**
Total: Services included in capitation:	27110912.51
Total: Services not included in capitation:	7102916.14
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**27089.33**
Services included in capitation:	21465.49
Services not included in capitation:	5623.84
Average Length of Stay on the Waiver:	338

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:							**144285.45**
Adult Day Service	☒	Hour	10	598.87	18.02	107916.37	
Adult Day Service - FFS	☐	Hour	10	1.00	18.02	180.20	
Adult Day Service Transportation	☒	Trip	10	264.12	13.65	36052.38	
Adult Day Service Transportation - FFS	☐	Trip	10	1.00	13.65	136.50	
Homemaker Total:							**4519392.98**
Homemaker	☒	Hour	157	567.46	38.43	3423775.58	

GRAND TOTAL:	**36856767.08**
Total: Services included in capitation:	29203771.23
Total: Services not included in capitation:	7652995.85
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**29181.92**
Services included in capitation:	23122.54
Services not included in capitation:	6059.38
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker - FFS	☐	Hour	43	663.01	38.43	1095617.39	
Individual Provider Total:							31140410.88
Individual Provider	☒	Hour	780	1298.25	24.53	24839936.55	
Individual Provider - FFS	☐	Hour	259	991.69	24.53	6300474.33	
Respite Total:							3975.20
Respite RN	☒	Hour	10	1.00	41.85	418.50	
Respite RN - FFS	☐	Hour	10	1.00	41.85	418.50	
Respite LPN	☒	Hour	10	1.00	34.75	347.50	
Respite LPN - FFS	☐	Hour	10	1.00	34.75	347.50	
Respite Homemaker	☒	Hour	10	1.00	38.43	384.30	
Respite Homemaker - FFS	☐	Hour	10	1.00	38.43	384.30	
Respite Individual Provider	☒	Hour	10	1.00	24.53	245.30	
Respite Individual Provider - FFS	☐	Hour	10	1.00	24.53	245.30	
Respite Adult Day Service	☒	Hour	10	1.00	18.02	180.20	
Respite Adult Day Service - FFS	☐	Hour	10	1.00	18.02	180.20	
Respite Adult Day Service Transportation	☒	Trip	10	1.00	13.65	136.50	
Respite Adult Day Service Transportation - FFS	☐	Trip	10	1.00	13.65	136.50	
Respite Home Health Aide (CNA)	☒	Hour	10	1.00	27.53	275.30	
Respite Home Health Aide (CNA) - FFS	☐	Hour	10	1.00	27.53	275.30	
Home Health Aide Total:							236819.53

GRAND TOTAL:	**36856767.08**
Total: Services included in capitation:	29203771.23
Total: Services not included in capitation:	7652995.85
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**29181.92**
Services included in capitation:	23122.54
Services not included in capitation:	6059.38
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Health Aide Agency (CNA)	☒	Hour	10	1.00	31.57	315.70	
Home Health Aide Agency (CNA) - FFS	☐	Hour	10	1.00	31.57	315.70	
Home Health Aide Non-Agency (CNA)	☒	Hour	10	440.21	27.53	121189.81	
Home Health Aide Non-Agency (CNA) - FFS	☐	Hour	10	417.72	27.53	114998.32	
Intermittent Nursing Total:							2538.20
Intermittent Nursing	☒	Visit	10	1.00	126.91	1269.10	
Intermittent Nursing - FFS	☐	Visit	10	1.00	126.91	1269.10	
Occupational Therapy Total:							4997.20
Occupational Therapy Over Age 18	☒	Hour	10	1.00	124.93	1249.30	
Occupational Therapy Over Age 18 -FFS	☐	Hour	10	1.00	124.93	1249.30	
Occupational Therapy Under Age 18	☒	Hour	10	1.00	124.93	1249.30	
Occupational Therapy Under Age 18-FFS	☐	Hour	10	1.00	124.93	1249.30	
Physical Therapy Total:							4997.20
Physical Therapy Over Age 18	☒	Hour	10	1.00	124.93	1249.30	
Physical Therapy Over Age 18 FFS	☐	Hour	10	1.00	124.93	1249.30	
Physical Therapy Under Age 18	☒	Hour	10	1.00	124.93	1249.30	
Physical Therapy Under Age 18 - FFS	☐	Hour	10	1.00	124.93	1249.30	
Speech Therapy Total:							4997.20
Speech Therapy Over Age 18	☒	Hour	10	1.00	124.93	1249.30	

GRAND TOTAL:	**36856767.08**
Total: Services included in capitation:	29203771.23
Total: Services not included in capitation:	7652995.85
Total Estimated Unduplicated Participants:	**1263**
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Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy Over Age 18 -FFS	☐	Hour	10	1.00	124.93	1249.30	
Speech Therapy Under Age 18	☒	Hour	10	1.00	124.93	1249.30	
Speech Therapy Under Age 18 - FFS	☐	Hour	10	1.00	124.93	1249.30	
Environmental Accessibility Adaptations Total:							172463.80
Environmental Accessibility Adaptations	☒	Unit	10	1.00	8623.19	86231.90	
Environmental Accessibility Adaptations - FFS	☐	Unit	10	1.00	8623.19	86231.90	
Home Delivered Meals Total:							471293.88
Home Delivered Meals	☒	Day	134	168.25	20.03	451586.36	
Home Delivered Meals - FFS	☐	Day	10	98.39	20.03	19707.52	
In-Home Shift Nursing Total:							52137.62
RN Agency	☒	Hour	10	1.00	51.45	514.50	
RN Agency - FFS	☐	Hour	10	1.00	51.45	514.50	
RN Non-Agency	☒	Hour	10	1.00	41.85	418.50	
RN Non-Agency -FFS	☐	Hour	10	1.00	41.85	418.50	
LPN Agency	☒	Hour	10	1.00	44.42	444.20	
LPN Agency - FFS	☐	Hour	10	1.00	44.42	444.20	
LPN Non-Agency	☒	Hour	10	141.11	34.75	49035.72	
LPN Non-Agency - FFS	☐	Hour	10	1.00	34.75	347.50	
Personal Emergency Response System Total:							64866.14

GRAND TOTAL:	**36856767.08**
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Total: Services not included in capitation:	7652995.85
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Factor D (Divide total by number of participants):	**29181.92**
Services included in capitation:	23122.54
Services not included in capitation:	6059.38
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response (Monthly Monitoring)	☒	Month	204	8.77	32.15	**57518.92**	
Personal Emergency Response (Monthly Monitoring) - FFS	☐	Month	19	9.17	32.15	**5601.49**	
Personal Emergency Response (Install)	☒	Unit	28	1.00	45.94	**1286.32**	
Personal Emergency Response (Install) - FFS	☐	Unit	10	1.00	45.94	**459.40**	
Specialized Medical Equipment and Supplies Total:							**33591.80**
Specialized Medical Equipment	☒	Unit	10	1.00	1679.59	**16795.90**	
Specialized Medical Equipment - FFS	☐	Unit	10	1.00	1679.59	**16795.90**	

GRAND TOTAL:	**36856767.08**
Total: Services included in capitation:	29203771.23
Total: Services not included in capitation:	7652995.85
Total Estimated Unduplicated Participants:	**1263**
Factor D (Divide total by number of participants):	**29181.92**
Services included in capitation:	23122.54
Services not included in capitation:	6059.38
Average Length of Stay on the Waiver:	339