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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §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 waivers 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 Disabilities

C. Waiver Number:IL.0142
Original Base Waiver Number: IL.0142.

D. Amendment Number:IL.0142.R07.05

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

03/01/23

Approved Effective Date: 03/01/23
Approved Effective Date of Waiver being Amended: 07/01/21

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. Increase the homemaker and homemaker respite rates from $25.66 to $26.92 effective March 1, 2023, or upon CMS approval. This increase is in response to the increased cost of living and previously established minimum wage rate increases in Illinois.

2. Update the Service Cost Maximum tables in Appendix B-2-a-Other to accommodate the homemaker and homemaker respite rate increases effective March 1, 2023, or upon CMS approval.

3. Revise Performance Measure D5 to reflect the correct frequency of contact by the HSP Rehabilitation Counselor, which is annually, rather than monthly. This is not a change in contact standards, but to correct an error in IL.0142.R07.04.

4. Revise Performance Measure D6 to reflect the correct frequency of contact by the MCO Care Coordinator, which is every 90 days, rather than monthly. This is not a change in contact standards, but to correct an error in IL.0142.R07.04.

5. Update Appendix I-2-a to reflect the increase in the homemaker and homemaker respite rates from $25.66 to $26.92 effective March 1, 2023, or upon CMS approval.

6. Update Appendix J-2-c-i to reflect the increase in the homemaker and homemaker respite rates, effective March 1, 2023, or upon CMS approval.

7. Update Appendix J-2-d to reflect the increase in the homemaker and homemaker respite rates, effective March 1, 2023, or upon CMS approval.

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**	B-2-a
☐ **Appendix C Participant Services**	
☒ **Appendix D Participant Centered Service Planning and Delivery**	Quality Improvement
☐ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant Rights**	

Component of the Approved Waiver	Subsection(s)
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	I-2-a
☒ Appendix J Cost-Neutrality Demonstration	J-2-c-i, J-2-d

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 §1915(c) of the Social Security Act (the Act).

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

Persons with Disabilities

C. Type of Request: 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.0142
Waiver Number:IL.0142.R07.05
Draft ID: IL.018.07.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/21
Approved Effective Date of Waiver being Amended: 07/01/21

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 in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Persons with Disabilities

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

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

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

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

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

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

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

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

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

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

Illinois mandatory managed care program, now called HealthChoice Illinois, operates statewide offering providers the opportunity to contract with MCOs in all Illinois counties. The Integrated Care Program (ICP), Family Health Plan/ACA Adults (FHP/ACA) and Managed Care Long Term Services and Supports (MLTSS) managed care programs are now incorporated in HealthChoice Illinois. 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, 2022.

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 §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 §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 §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 §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:

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Winsel

First Name: Pamela

Title: Senior Public Service Administrator

Agency: Department of Healthcare and Family Services

Address: 201 South Grand Avenue East 2nd Floor

Address 2:

City: Springfield

State: **Illinois**

Zip: 62763

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

Fax: (217) 557-2780

E-mail: pamela.winsel@illinois.gov

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

Last Name: Lyle

First Name: VanDeventer

Title: Home Services Program

Agency: Department of Human Services, Division of Rehabilitation Services

Address: 100 S Grand Ave East

Address 2:

City: Springfield

State: **Illinois**

Zip: 62762

Phone: (217) 785-7639 **Ext:** ☐ **TTY**

Fax: (217) 557-0142

E-mail: lyle.vandeventer@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 §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

04/19/2023

State Medicaid Director or Designee

Submission Date: Apr 11, 2023

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: 62626

Phone: (217) 524-7331 **Ext:** ☐ **TTY**

Fax: (217) 782-2570

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.

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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

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

The MA and OA work cooperatively to review rates and provider claims. The MA implements procedures that provide assurance that claims will be coded and paid in accordance with the reimbursement methodology specified in the waiver.

For customers enrolled in a Managed Care Organization (MCO), the MA's internal and external auditing procedures will ensure that payments are made to a only for eligible customers who have been properly enrolled in the waiver.

The MCOs are responsible for reviewing payments made directly to providers for waiver services. The MCOs must have an internal process to validate payments to waiver providers. This includes the claims processing system verifying a customer's waiver eligibility prior to paying claims.

CONTINUED FROM APPENDIX I-2-a
IL.0142.R07.00, effective 7/1/2021
Home Delivered Meals (HDM):
The home-delivered meal rate is standardized and are based on rates set under Title III of the Older Americans Act. The administrative rule specifies that the cost of HDM can be no more than what it would cost for an IP to prepare the meal. The rates are not geographically based and do not include direct or indirect administrative costs. The rate is subject to COLA when enacted and published on the OA's website under HSP. The HDM rate has not been reviewed in the last five years. The State will perform a rate review 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. In the future, the HDM rate will be reviewed minimally every five years.
HDM rate: $15.00

IL.0142.R07.00, effective 7/1/2021
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.

IL.0142.R07.00, effective 7/1/2021
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 $1500, three bids are required, and the lowest bidder is selected. If the lowest bidder cannot provide timely services, the next lowest bid may be selected. If three bids cannot be obtained or a bid is the sole source for lack of available vendors, a formal justification as to why three 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 a total of $25,000 over a five-year period.

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The Illinois Department of Human Services, Division of Rehabilitation Services

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

Healthcare and Family Services (HFS) as the Medicaid Agency (MA) maintains an interagency agreement with the Illinois Department of Human Services, Division of Rehabilitation Services (DHS-DRS) as the Operating Agency (OA), which outlines the HCBS waiver responsibilities of both agencies. The OA is responsible for customer eligibility, Person Centered Plan (PCP) development, Home Services Program (HSP) budgeting, enrolling waiver providers, assuring PCP are implemented and that services and providers meet standards established in the approved waiver and governing rules. The MA enrolls providers in Medicaid, provides oversight, consultation, and monitoring of waiver operations, processes federal claims and maintains an appeal process. The interagency agreement is reviewed at least annually and updated as needed. The MA's Medical Policy Review Committee reviews all waiver rule and policy changes.

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

There are two broad types of program reviews: record reviews and onsite comprehensive provider reviews. The MA randomly selects the customer sample from the Medicaid Management Information System (MMIS) using claims for waiver services in a specific time period. The onsite provider reviews are more comprehensive than the record reviews. The onsite reviews assess how the waiver program operates overall by reviewing components of customer eligibility; PCPs; provider qualifications; health, welfare, and safety; care coordination and how the system operates and communicates customer needs and issues.

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

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

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

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

Person Centered Plan (PCP) Development—customer records are examined to determine that all assessed customer needs, goals, and risks are addressed in a PCP; services are provided according to the PCP including engagement of the customer in the development of his/her PCP, goals are set and progress towards goals is indicated; PCP are signed and dated by the customer and the HSP Rehabilitation Counselors or MCO Care Coordinators validating inclusion and agreement; customers are routinely contacted by the HSP Rehabilitation Counselors and MCO Care Coordinators per applicable waiver requirements; PCPs are updated when the customer's needs change; and that choice of services and providers was offered to the customer. PCPs are also reviewed for completeness, accuracy, and timeliness.

Health, Safety, and Welfare—customer records are examined to determine that customers are aware of how and to whom to report abuse, neglect, and exploitation; and each customer with an Independent Provider (IP) has a backup plan.

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Illinois' mandatory managed care program, now called HealthChoice Illinois, began operating statewide effective January 1, 2018, offering providers the opportunity to contract with Managed Care Organizations (MCOs) in all Illinois counties; additional MCOs are available only to Cook County customers. The Integrated Care Program (ICP), Family Health Plan/ACA Adults (FHP/ACA) and Managed Long Term Services and Supports (MLTSS) managed care programs are now incorporated in HealthChoice Illinois. Customers enrolled in the 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.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

The State's Quality Improvement System (QIS) assures that the OA and Managed Care Organizations (MCOs) are complying with the federal assurances and performance measures that fall under the functions delegated to them by the Medicaid Agency (MA). The sources of discovery vary, and the sampling methodology for discovery is based on either a 100% review or the use of a statistically valid proportionate and representative sample. The type of sample used is indicated for each performance measure. The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the Operating Agency (OA) and the MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA pulls the sample annually and will adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

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

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

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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 evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☒
Qualified provider enrollment	☒	☒	☒

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
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 States quality improvement strategy, provide information in the following fields to detail the States 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**	☐ **Weekly**	☒ **100% Review**

Agency		
☒ **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):*

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific performance measures, which are specified in the State's contracts with MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the External Quality Review Organization (EQRO), the MA monitors both compliance of performance measures and timeliness of remediation for those waiver customers enrolled in an MCO through customer surveys and quarterly record reviews. Customers in MCOs are included in the representative sampling. Many of the performance measures are reported on and discussed during the quarterly Quality Management Committee meetings. During these meetings, the responsible entity will share results and all parties will discuss remediation and quality improvement strategies.

b. Methods for Remediation/Fixing Individual Problems

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

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

A3: The MA will require completion of overdue reports. The MCO will submit a plan of correction within 30 days.

A4: The OA and MA monitor to ensure slots remain below capacity. If slots are getting close or going over capacity, the MA will request a waiver amendment to increase capacity.

A5: The provider is notified of interview responses. The provider requires all customers be provided required support in making life choices and documents in case file at facility.

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **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 SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☒	**Disabled (Physical)**	0	59	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

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

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

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

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

Specify:

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

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

Appendix B: Participant Access and Eligibility

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

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

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

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to

that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

◉ **Other:**

Specify:

Below are Determination of Need scores and associated Service Cost Maximums (SCM) effective 7/1/2020. SCMs may be updated in the future, based on increases in provider rates or other factors that impact the cost of waiver services.

DON score	SCM
29-32	$2,253
33-40	$2,587
41-49	$2,878
50-59	$3,440
60-69	$4,045
70-79	$4,370
80-100	$4,697

Amendment IL.0142.R07.01 updated the SCMs effective 12/1/2022

DON score	SCM
29-32	$2,507
33-40	$2,877
41-49	$3,200
50-59	$3,824
60-69	$4,496
70-79	$4,857
80-100	$5,221

Amendment IL.0142.R07.05 updated the SCMs effective 3/1/2023, or upon CMS approval.

DON score	SCM
29-32	$2,516
33-40	$2,887
41-49	$3,211
50-59	$3,837
60-69	$4,511
70-79	$4,874
80-100	$5,239

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 Level of Care. The range of scores and corresponding SCM is indicated under B-2 a. This amount directly corresponds to the amount the State would expect to pay for the nursing care component of institutionalization if the customer chose institutionalization.

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

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

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

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

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

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

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

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

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

If a customer has complex medical needs that cannot be served within the allowable SCM, the HSP Counselor may request an exceptional care (EC) rate. The EC rate is determined by HFS and based on higher rates paid in nursing facilities that serve medically complex or deliver special rehabilitative services, similar to that of the customer. 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	32401
Year 2	33373
Year 3	34373
Year 4	35405
Year 5	36468

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

- (●) **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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)*:

- ( ) **§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**
- [x] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional state supplement recipients**
- [x] **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)**
- [x] **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)**
- [x] **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)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

The following groups are also included:
1) Adults age 19 and above without dependent children and with income at or below 138% of the Federal Poverty Level (Adult ACA Population) as provided in Section 1902(a)(10)(A)(i)(VIII)of the Social Security Act (the Act) and Section 42 CFR 435.119 of the federal regulations.
2) Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets pertaining to Title IV-E children under Section 1902(a)(10)(A)(i)(IX)of the Act and Section 42 CFR 435.150 of the federal regulations.
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 §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 §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 (SSI 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 §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 the customers equals the maximum income a customer can have and be eligible under 435.217 group.

- ○ **The following dollar amount**

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

  Specify:
- ○ **Other**

  Specify:

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

- ◉ **Not Applicable**
- ○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §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 a government agency under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the

educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

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

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

The entry point into the waiver, or initial level of care determination, is through the Universal Screening process which became law on July 1, 1996 (Public Act 89-499). This law requires all customers seeking admission into a nursing facility on or after July 1, 1996 to be screened to determine the need for nursing facility placement prior to being admitted. This screening is required regardless of income, assets or payment source. The standardized screening tool used for assessment is the Determination of Need (DON). Those customers identified through the screening process as needing nursing facility level of care are afforded the opportunity to select a supportive living facility as long as their needs can be met in that setting.

The necessity for long term care is based on the determined need for a continuum of home and community-based services that ultimately prevent inappropriate or premature placement in a group care facility. The extent and degree of a customer’s need for long term care is determined on the basis of consideration of pertinent medical, social and psychological factors as measured by application of the DON (IL488-2069W).

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

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:

HSP Rehabilitation Counselors conduct the level of care evaluations and reevaluations utilizing the Determination of Need as described above.

For customers enrolled in an MCO, the redeterminations will be conducted by the OA.

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: Eligibility Report (WebCM)

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with the MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the External Quality Review Organization (EQRO), the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants 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 States 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 60 days.

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

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

The Mini Mental State Exam (MMSE) is a component of the Determination of Need and is administered during each assessment/redetermination to assist in determining whether or not the customer can appropriately direct their care. If so determined, customers may choose between service providers, and may direct and train their caregiver. If it is determined that the customer does not have this capacity and no responsible family member or guardian is available, then a provider such as homemaker or home health agency is used.

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.

MCOs are required to enter into contracts with a sufficient number of such providers within each county in the contracting area. MCO Care Coordinators are trained to educate customers and provide an informed choice on the available providers and description of HCBS setting if service is to be delivered outside of the home. For customers who do not express a choice amongst available contracted providers, the MCO shall fairly distribute such customers, taking into account all relevant factors, among those providers who are willing and able to accept the customer and who meet applicable quality standards.

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

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

For customers enrolled in an MCO, the MCO will maintain the forms for a minimum of ten years from the final date of the contract period or from the date of completion of any audit, whichever is later. MCOs' documentation is stored electronically in their respective secure electronic care management data systems and backed up on secure data servers. MCOs do not store physical documents; these are shredded via HIPAA compliant PHI disposal after they are scanned and uploaded into their care management data systems.

Appendix B: Participant Access and Eligibility

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

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

The entities under contract with the OA serve as access points and are integrated into the communities. In some areas, the HSP Rehabilitation Counselors interact on a daily basis with a wide variety of individuals with varying backgrounds, cultures, and languages. The HSP Rehabilitation Counselors have resources available to communicate effectively with individuals of limited English profiency in their community, including bilingual staff as needed, interpreters, and translated forms. Interpreter services are provided at no cost to customers.

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Service**		
Statutory Service	**Homemaker**		
Statutory Service	**Individual Provider**		
Statutory Service	**Respite**		
Extended State Plan Service	**Home Health Aide**		
Extended State Plan Service	**Occupational Therapy**		
Extended State Plan Service	**Physical Therapy**		
Extended State Plan Service	**Speech Therapy**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Home Delivered Meals**		
Other Service	**In-Home Shift Nursing**		
Other Service	**Intermittent Nursing**		
Other Service	**Personal Emergency Response System**		
Other Service	**Specialized Medical Equipment**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

Adult Day Service (ADS) is direct care and monitoring of customers in a community-based setting for any portion of a 24-hour day for the purpose of promoting social, physical, and emotional health and well-being and offering an alternative to an institutional setting. ADS are provided only when the social, emotional, and physical needs of the customer cannot be met in the home through other available services.

By definition, ADS is to be offered as a least restrictive alternative to nursing facility care or care within the home. In addition, ADS facilities are subject to the new federal HCBS rule, and their compliance with the rule will be assessed and enforced through the State's HCBS statewide transition plan.

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

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

The OA will provide a maximum of two one-way trips per day.

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 Transportation
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 Transportation

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Ill Adm Code 686.100

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Adult Day Service

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il 686.100

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

Services consisting of general household activities (meal preparation and routine household care) and personal care provided by a trained homemaker, when the customer regularly responsible for these activities is unable to manage the home care for him or herself and is unable to manage a personal assistant. This service will only be provided if personal care services are not available or are insufficient to meet the care plan or the customer cannot manage a personal assistant. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

This service will be provided if personal care services are not available or are insufficient to meet the care plan or the customer cannot manage a personal assistant. The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

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 Il. Adm. code 686.200

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Individual Provider

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

Independent Providers (IP) are non-agency based personnel. An IP can also be a Personal Assistant (PA), CNA, LPN, or RN. The IP assists with eating, bathing, personal hygiene, and other activities of daily living 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 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 act due to grass roots advocacy efforts of the disability community. Other providers exempt from the act include independently hired licensed providers including RNs, LPNs, and therapists. The Department of Financial and Professional Regulations in accordance with their licensure requirements covers licensed providers. Independent CNAs are covered through the Health Care Worker Registry.

The Illinois State Police 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 the option to conduct HCWBCs on IP, at no cost to the customer. The OA and MCO provides information to the customers on how to request 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 care agency staff have HCWBC when they conduct compliance reviews. The MA verifies compliance during onsite monitoring reviews for home health, homemaker, and adult day care 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 Department on Aging conduct reviews every two years 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 is based on the determination of need assessment conducted by the HSP Counselor and the service cost maximum determined by the DON score. Independent Provider services cannot be duplicative of services offered under EPSDT.

The customer's legally-responsible family members (89 Ill. Adm. Code 676.30) cannot be paid as care providers.

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	Independent 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:

Independent Provider

Provider Qualifications

License *(specify):*

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

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

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 IL Adm. Code 686.10

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

At time of initial employment 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:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the customer. Services are limited to independent providers, homemaker, nurse, adult day care, 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 adult day care setting.

Respite services can be provided by a fairly wide range of providers in terms of required credentials and in terms of skills. This reflects the very wide range of needs and services provided for the program's participants. Credential reviews for different provider types are done by different agencies, and the frequency of some credential reviews is dictated by a variety of statutes. The Nurse Practice Act, for example, dictates the frequency and content of credential reviews for LPNs and RNs. Several other laws address the content and frequency of credentialing for therapists and home health aides. There is even a statute which requires homemaker providers to get background checks, and now there is a similar but separate law for personal assistants. These laws are then implemented by the IL Department of Professional Regulation and the IL Department of Public Health.

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

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

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

- ☒ **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
Individual	Home Health Aide
Agency	Homemaker
Agency	Home Health Agency
Agency	Adult Day Care
Individual	RN
Individual	Independent Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:

LPN

Provider Qualifications

License *(specify):*

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:

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:

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:

Homemaker

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Admin. code 686.200

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Every three years

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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Admin. code 686.100

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Every three 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:

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:

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:
Individual
Provider Type:

Independent Provider

Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Admin. code 686.10

Verification of Provider Qualifications

Entity Responsible for Verification:

The customer verifies inititally and DRS and HFS verify during monitoring.

Frequency of Verification:

Prior to being hired

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:**

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

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

Service Definition *(Scope):*

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

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

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

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

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	Home Health Aide

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:

DRS

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:

Individual

Provider Type:

Home Health Aide

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

210 ILCS 45/3-206

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

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:

Occupational Therapy

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

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

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

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

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

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	Occupational 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: 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:

DRS

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:

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:

Physical Therapy

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

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:

DRS

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:

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:

Speech Therapy

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

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	Speech Therapist

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify)*:

210 ILCS 55

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: Extended State Plan Service
Service Name: Speech Therapy

Provider Category:

Individual

Provider Type:

Speech Therapist

Provider Qualifications

License *(specify):*

Speech and Language Pathologists are licensed pursuant to the requirements in (225 ILCS 110/) Illinois Speech-Language Pathology and Audiology Practice Act.
Each applicant for a speech-language pathology or audiology license shall file an application with the Department of Financial and Professional Regulation-Division of Professional Regulation (Division), on forms provided by the Division. The application shall include certification of a master's or doctoral degree from a program approved by the Division; passage of the PRAXIS examination or certification from the American Speech-Language-Hearing Association or from the American Board of Audiology. Exam scores shall be submitted directly to the Division from the testing service. The application shall also include certification of completion of the equivalent of 9 months of full-time supervised professional experience; and the required fees set forth by the Department. The Division, upon recommendation of the Board, will also accept a Certificate of Clinical Competence in Speech-Language Pathology or Audiology awarded by the American Speech-Language-Hearing Association's Clinical Certification Board or certification in audiology from the American Board of Audiology.

To the extent that the SLT services being or to be provided to children fall within the EPSDT portion of Illinois' state plan, waiver staff ensure that the participant uses State Plan services instead, as applicable.

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:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

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

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

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.

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

The cost of environmental modification, when amortized over a 12 month period and added to all other monthly service costs, may not exceed the service cost maximum (89 Ill. Adm. code 679) established for the customer's case. In addition, the total cost for purchase of all environmental modifications and assistive equipment purchase, rentals, and repairs shall not exceed $25,000 every 5 years (89 Ill. Adm. Code 686.705(d)).

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 Il. Adm. code 686.600

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

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: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

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

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 Il. Adm. Code 686.500

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

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

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:**

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

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

Service Definition *(Scope):*

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

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

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

The Person Centered Plan includes the type of service(s) to be provided to the customer, the specific tasks involved, the frequency with which the specific tasks are to be provided, the number of hours each task is to be provided per month, and the rate of payment for the service(s). Each type of nursing is a specific service with specific codes. The Person Centered Plan and its contents are maintained in the program's IT system and payments made on behalf of customers are edit checked against the Person Centered Plan. In addition, staff are trained as to what type of nursing service is most cost effective and/or most appropriate for a given situation. With the Electronic Visitation Verification program now used for all individual providers, the presence of more than one provider serving a participant at the same time is allowed for training situations of one provider to another. Nonetheless, this occurrence is placed on an exception report for the explicit purposes of trying to prevent duplicates. Other reports are also produced to detect duplicates and most customers who use nurses extensively also have a special time keeping system which would detect duplication. Finally, if a participant receives a State Plan or EPSDT service during the same pay time period as a waiver provider, the FFP claim is rejected. Rejects are closely monitored.

Overtime will be billed and claimed with the use of supplemental codes added to appropriate hcpc codes, i.e. there would be a single supplemental code for overtime hours, but it could be added to the hcpc codes for any of the possible individual type service providers, thus allowing the billing, reporting and tracking of overtime.

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):*

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: Other Service
Service Name: In-Home Shift Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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: 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):*

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: Service Specification

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

Service Type:
Other Service

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

specified in statute.

Service Title:

Intermittent Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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

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

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

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

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's Person Centered Plan. The Person Centered Plan includes the type of service(s) to be provided to the customer, the specific tasks involved, the frequency with which the specific tasks are to be provided, the number of hours each task is to be provided per month, and the rate of payment for the service(s). Each type of nursing is a specific service with specific codes. The Person Centered Plan and its contents are maintained in the program's IT system and payments made on behalf of customers are checked against the Person Centered Plan. In addition, staff are trained as to what type of nursing service is most cost effective and/or most appropriate for a given situation. With the Electronic Visitation Verification Program now used for all individual providers, the presence of more than one provider serving a customer at the same time is allowed for training situations of one provider to another. Nonetheless, this occurrence is placed on an exception report for the explicit purposes of trying to prevent duplicates. Other reports are also produced to detect duplicates and most customers who use nurses extensively also have a special time keeping system which would detect duplication. Finally, if a customer receives a State Plan or EPSDT service during the same pay time period as a waiver provider, the FFP claim is rejected. Rejects are closely reviewed.

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

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

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

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

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
Individual	LPN
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intermittent Nursing

Provider Category:
Individual
Provider Type:

Registered Nurse

Provider Qualifications
License *(specify):*

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: Other Service
Service Name: Intermittent Nursing

Provider Category:
Individual
Provider Type:

LPN

Provider Qualifications
License *(specify):*

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: Other Service
Service Name: Intermittent Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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:

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:**

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

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

Service Definition *(Scope):*

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

Personal Emergency Response System (PERS) is an electronic device that enables certain customers to secure help in an emergency. The customer may also wear a portable "help" button to allow for mobility. The system is connected to the customer's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center. PERS services are limited to those customers who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. This service has two components: an initial installation fee and a monthly service fee.

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

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Home Response

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Emergency Home Response

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Adm. code 686.300

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

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

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items, which are not of direct medical or remedial benefit to the customer. All items shall meet applicable standards of manufacture, design and installation.

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

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

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

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

Provider Category:

Agency

Provider Type:

Medical Suppliers

Provider Qualifications

License *(specify):*

225 ILCS 51

Certificate *(specify):*

N/A

Other Standard *(specify):*

68 Il. Adm. Code 1253

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Pharmacies

Provider Qualifications

License *(specify):*

225 ILCS 85

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

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

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

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

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

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

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

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

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

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

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

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

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

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

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

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

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) 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.*

☐ **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.*

◉ **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.

Neither parents or step-parents of minor children, or legally responsible family members, or minor children (per 89 Ill. Adm. Code 676.30) can be paid as an Individual Providers (IPs) for waiver customers. Minor children may serve as an IP only after they have been granted a work permit by the local school district, and as long as they meet all provider qualifications, and when no other appropriate service provider can be located. However, they cannot provide services to their parent (or step-parent). The case file must contain documentation that a serious and ongoing effort is being made to locate another appropriate service provider; or the Home Services Program (HSP) Rehabilitation Counselor or MCO Care Coordinator has determined, based on documentation in the case file, that the family member is the most appropriate service provider due to the care involved, or the existing circumstances. Payment will not be paid for services to a minor customer when the service was provided by the child's parent (or step-parent), or when services are provided by a customer's spouse. Family members must meet the same IP standards as those IPs who are unrelated to a customer. Time sheets are signed by the customer to verify that the services were 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 two week 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).

Verification of care may be determined from other sources as well. For example, family members, friends, neighbors, social workers, other providers can serve as information sources concerning the customer's care. The HSP Rehabilitation Counselor 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 or MCO Care Coordinator may follow up by conducting an unannounced home visit or may schedule a nursing evaluation.

The HSP Rehabilitation Counselor or MCO Care Coordinator also verifies that services are provided in accordance with the customer's Person Centered Plan (PCP). During redeterminations the Counselor notes the customer's general condition, hygiene and cleanliness, considers the customer's nourishment status, notes any odors in the house as well as cleanliness of the home, etc. If discrepancies are identified, the HSP Rehabilitation Counselor 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 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 a homemaker through an agency-based provider.

○ **Other policy.**

Specify:

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

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

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

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

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

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

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

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

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

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

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

The following requirements apply for the remaining HCBS waiver services:

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

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

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

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

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

For HealthChoice Illinois, MCOs shall enter into a contract with any willing and qualified provider in the contracting area that renders waiver services so long as the provider agrees to MCO's rate and adheres to MCO's quality requirements. To be considered a qualified provider, the provider must be in good standing with the MA's Fee for Service (FFS) Medical Program. MCO may establish quality standards in addition to those State and Federal requirements and contract only with providers that meet such standards. Such standards must be approved by the MA, in writing, and MCOs may only terminate the contract of a provider based on failure to meet such standards if two criteria are met a) such standards have been in effect for at minimum one (1) year, and b) providers are informed at the time such standards come into effect.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:#&% of OA HSP Rehab Counselors (RCs) and MCO Care Coordinators (CCs) who meet training requirements in accordance with state requirements and the approved waiver prior to providing waiver services. N:# of OA HSP RCs and MCO CCs who meet training requirements in accordance with state requirements and the approved waiver prior to providing waiver services D:Total number of OA HSP RCs and MCO CCs.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C6: #&% of OA HSP Rehab Counselors and MCO Care Coordinators who continue to meet training requirements in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. N: # of OA HSP RCs &MCO CCs who continue to meet training reqs in accordance with state reqs &approved waiver prior to continuing to provide waiver svcs. D:Total # OA HSP RCs & MCO CCs

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

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

Agency		
☒ **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:
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:

Performance Measure:
C6: #&% of OA HSP Rehab Counselors and MCO Care Coordinators who continue to meet training requirements in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. N: # of OA HSP RCs &MCO CCs who continue to meet training reqs in accordance with state reqs &approved waiver prior to continuing to provide waiver svcs. D: Total # OA HSP RCs & MCO CCs

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

For training, the MA will request reports from the OA and the MCOs to verify that Home Services Program Rehabilitation Counselor and MCO Care Coordinators initially meet and continue to meet, provider training requirements. These reports will also be shared during the quarterly meetings.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 Medicaid Agency (MA) would deny the claim and make the provider inactive. Additionally, the MA would identify vulnerabilities in the system and take appropriate action. Remediation is required within 30 days.

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

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

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

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

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

◉ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable -** The state imposes additional limits on the amount of waiver services.

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

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

☐ **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.

Settings in this waiver will comply with Federal Home and Community Based Services requirements per Attachment #2 in this renewal application.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Plan

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

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

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

For customers enrolled in an Managed Care Organization (MCO), qualifications for the Care Coordinators vary within each of the MCOs. Customer are assigned to specific Care Coordinators based on individual need and identified risk. At a minimum, qualifications include the following license or education level:

1) Registered Nurse (RN),
2) Licensed Clinical Social Worker (LCSW);
3) Licensed Marriage and Family Therapist (LMFT);
4) Licensed Clinical Professional Counselor (LCPC);
5) Licensed Professional Counselor (LPC);
6) PhD;
7) Doctorate in Psychology (PsyD);
8) Bachelor or Masters prepared in human services related field;
9) Licensed Practical Nurse (LPN)

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

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. *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 or MCO Care Coordinator. Both utilize skills to engage customer to participate in and direct the PCP process. The development of these skills, and the approach to customer inclusion at all levels within the PCP development, requires on-going training and is a critical component during the hiring process and the ongoing supervision of staff.

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

d. 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 is scheduled at the convenience of the customer and other parties that the customer wishes to have included. The face-to-face assessment visits are often 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 HSP Rehabilitation Counselor.

MCO Process:

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

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

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

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

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

The MCO contract specifies expectations for waiver customers, including content of and purposes for the PCP. As part of

its work on behalf of the MA, the EQRO reviews assessments as part of its pre-implementation record review, onsite post-implementation record review, as well as in quarterly record reviews, to ensure the assessments meet contractual requirements.

c) Informing customer of services available under the waiver.

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

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

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

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

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

MCO Process:
Comprehensive assessments are developed by each MCO. The MCO contract specifies expectations for waiver customers, including content of and purposes for PCP.

After the comprehensive assessment has been completed by the Care Coordinator, and the array of services have been presented to and discussed with the customer, the Care Coordinator, the customer and/or their representative(s) formulate a PCP that addresses their goals, strengths, and barriers/risks in consideration of these goals, and the mutually agreed upon activities for achievement of these goals. Personal preferences, such as cultural preferences and provider preferences for language and gender, are integral to the development of the PCP. The PCP includes the type, amount, frequency, and duration of waiver services, and includes services and supports not covered under the waiver, all related to the needs and preferences expressed by the customer.

The strength of the MCO model is the actual coordination of health care needs and long-term services and supports. MCOs develop a holistic PCP and are responsible for monitoring its implementation, along with the customer.

On behalf of the MA, the EQRO reviews the MCOs comprehensive assessments as part of its pre-implementation record review, onsite post-implementation record review, as well as in quarterly record reviews to make sure the assessments meet contractual requirements.

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

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

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

Services are coordinated by the Care Coordinator, who is responsible for the identification, authorization, and assignment to the responsible service provider in coordination with and direction from the customer and/or their representative.

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

OA Process:
The OA mandates that upon initial determination of eligibility and every redetermination thereafter, the HSP Rehabilitation Counselor must provide the Customer’s Bill of Rights to the customer. This brochure outlines the responsibility of the customer and the responsibilities of the MA and OA as it relates to receiving services. Included in these responsibilities of the customer is the responsibility to notify the HSP Rehabilitation Counselor of any changes in their 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 of changes in the customer’s status. OA policies and training outline the responsibilities of the HSP Rehabilitation Counselor. These responsibilities include development and continual monitoring of the PCP.

MCO Process:
The MCO Care Coordinator is responsible for the execution of the PCP, which includes monitoring the provision of waiver services and risk mitigation strategies. The customer’s role is clearly defined in the PCP, and the customer is responsible for actively participating and providing feedback. The Customer’s Bill of Rights, as described above, is provided, explained and reviewed with the customers.

The MA mandates that upon initial assessment and every assessment thereafter, the Care Coordinator provides the rights and responsibilities brochure to the customer. These brochures outlines the responsibility of the customer and the responsibilities of the MA and MCO as it relates to services. Included in these responsibilities of the customer is the responsibility to notify the Care Coordinator of any changes in their status, i.e., hospitalizations, changes in needs, changes in financial status, etc. The MA requires this brochure not only be given, but also explained and reviewed with the customer. Documentation in the customer's case record must support that this requirement was met. Provider agencies are directed to notify the Care Coordinator of changes in the customer’s status. MCO policies and training outline the responsibilities of the Care Coordinator. These responsibilities include development and continual monitoring of the PCP.

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

OA Process:
The HSP Rehabilitation Counselors conduct redeterminations of eligibility on an annual basis to review and/or revise the PCP with the customers or at times when there is a significant change. The PCP is designed to meet all needs of the customer as identified on the DON and to identify other needs or risks that the customer may have.
If the customer's living situation has changed to the extent that services need to be revised, the HSP Rehabilitation Counselor may complete a temporary service plan addendum that modifies the level of care until the next reassessment is completed. If there are new needs or if the new cost of services exceeds the SCM, the HSP Counselor 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 Counselor is 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 concerning their case. Customers are also informed of their responsibilities including completing and submitting necessary personal and contact information to facilitate timely eligibility determination and provision of services; how to properly complete, sign, and/or submit necessary documentation in accordance with program guidelines and assisting the OA with gathering the information necessary to determine eligibility; and reporting all changes in circumstances which may affect eligibility or continued eligibility for services to OA, as soon as known.

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

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

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

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

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

and to 42 CFR 441.301(c)(4)(5), by the end of the transition period as outlined in Illinois' most recent and/or approved Home and Community-Based Services (HCBS) 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 assess for customer needs, as well as evaluating risks. They work with the customer to identify the resources and strategies to mitigate these risks through the linkage and delivery of services, ultimately to prevent institutionalization and for the customer to be successful in community residency. These risks are identified in the assessment tools utilized and during the conversations and interviews that are critical elements of the process. For example, if the customer is at nutritional risk, utilizing a home care worker or home delivered meals service may be included in the PCP to mitigate this risk.

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

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

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

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

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

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

MCO Process:

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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

MCO Process:

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

While the OA and the MCOs have day-to-day responsibility for the completion and implementation of the PCP, the PCP is subject to oversight from the MA. This oversight is accomplished through the MA's Quality Improvement System using a statistically valid sample representative sampling methodology having a 95% confidence level and a 5% margin of error. Once the sample is selected by the MA, it is provided to the reviewing entity responsible for monitoring the OA (a Quality Improvement Organization, or QIO) and MCOs (an External Quality Review Organization or EQRO).

The QIO 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 OA by individual PM, along with recommendations for remediation of findings and/or needed systemic improvement(s). Timeliness of remediation is reported back to the MA based on the requirements of each PM, either immediate, 30, 60, 90 days and any remaining outstanding remediation. Information related onsite record is also shared during quarterly meetings between 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 MA and MCO by individual PM, along with recommendations for remediation of findings and/or needed systemic improvement(s). Timeliness of remediation is reported back to the EQRO and MA based on the requirements of each PM, either immediate, 30, 60, 90 days and any remaining outstanding remediation. Information related onsite record is also shared during quarterly meetings between MA and MCO.

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 PCP forms.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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 States quality improvement strategy, provide information in the following fields to detail the States 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**

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:

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D3: Number and percent of OA and MCO customers' 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**

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

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

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

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

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D6: Number and percent of MCO customers who received contact every 90 days by their MCO Care Coordinator in an effort to monitor service provision or gaps in service delivery. N: Number of MCO customers who received contact every 90 days by their MCO Care Coordinator in an effort to monitor service provision or gaps in service delivery. D: Total number of MCO customers reviewed.

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

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

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants 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 Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error

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

Data Aggregation and Analysis:

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

Performance Measure:
D8: Number and percent of OA and MCO waiver customers 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**

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

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**

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 or MCO Care Coordinator. Remediation must be completed within 60 days.

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

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

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

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

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

D7: If PCPs are untimely, the OA/MA will require completion of overdue PCPs and justification from the care coordinator. If PCPs are not updated when there is documentation that a customer's needs changed, the OA/MCO will require an update. In both cases the OA/MCO may require a plan of correction for Care Coordinator training. Remediation within 60 days.

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

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

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **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 since the early 1980s. Customers may either hire their own Individual Provider (IP) or use an agency provider. Customers typically opt to use IPs.

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

As the employer, customers must sign timesheets to approve and verify the hours that the IP has worked. Signed timesheets are then forwarded to the Operating Agency (OA) district office for further verification and payment. 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.

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

◉ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's

representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

○ **Waiver is designed to support only individuals who want to direct their services.**

◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☒ **Governmental entities**

☐ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

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

Provide the following information

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

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

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

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

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

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

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

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

Specify:

Supports furnished when the participant exercises budget authority:

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

Specify:

Additional functions/activities:

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

Medicaid agency

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

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

☐ **Other**

Specify:

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

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

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

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

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

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

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

☒ **Waiver Service Coverage.**

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Individual Provider	☒
Home Delivered Meals	☐
Adult Day Service	☐
In-Home Shift Nursing	☒
Environmental Accessibility Adaptations	☐
Specialized Medical Equipment	☐
Respite	☒

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Speech Therapy	☒
Home Health Aide	☒
Homemaker	☐
Occupational Therapy	☒
Intermittent Nursing	☒
Physical Therapy	☒
Personal Emergency Response System	☐

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

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

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

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

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

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

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

HCOP services include:

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

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

-Assisting or representing customers in their appeals of decisions regarding services and, if necessary, represent them in court.

-Working with the department, community groups, and advocacy organizations to resolve system problems.

-Providing public education programs on the rights of customers with disabilities and other related issues.

-Providing information and referral to related services.
When a complaint is presented to the Ombudsman, the Ombudsman representative brings the customer's complaints to one of the Operating Agency's (OA) zone offices. An Ombudsman representative is assigned to each zone and is responsible for handling complaints and questions in his/her zone. The Ombudsman representatives meet weekly to ensure consistent responses.

The OA provides each customer with a copy of the Home Services Program (HSP) Appeal Fact Sheet initially, at each redetermination and upon request. The HSP includes information on the right to appeal. Ombudsman representatives are also available to assist customers through the appeal process.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

During the Person Centered Plan (PCP) development process, Home Services Program (HSP) Rehabilitation Counselor review many factors to determine if the customer has the ability to self-direct. Examples of items reviewed would include medical information, psychological information, and interviews with the customer and their family members.

If the customer has the capacity to self-direct and chooses an Independent Provider (IP), the PCP is developed, and the customer is provided information about becoming an employer of the IP.

If the customer does not have the capacity to self-direct, he or she may choose a family member or guardian to manage the IP or they may choose an agency-based provider to provide their service.

If a customer chooses to self-direct and there are problems with the IP such as fraud or abuse by the customer; or situations where the customer's physical or mental health regresses, the HSP Rehabilitation Counselor will work with the customer to find an agency provider to replace the IP. Like any change in the PCP, this action may be appealed. Until the appeal is resolved, services will remain at the same level if the customer asks for continuation of services within 10 days of receiving the adverse determination letter. When transitioning from self-directed to agency-based services, the HSP Rehabilitation Counselor assures that there are no disruptions in services.

The Centers for Independent Living (CIL), in conjunction with the Operating Agency (OA) provides training to assist customers in the management of Independent Providers (IP). When a customer goes from self-directing services to receiving agency-based services and wants to go back to self-direction, the OA suggests that the customer participate in the training.

When a customer is in between IPs, the OA immediately increases the PCP and contacts a homemaker agency to maintain continuity of care until the customer finds a new IP.

For customers enrolled in a Managed Care Organization (MCO), the MCO Care Coordinator is the lead for waiver PCP development, implementation, and monitoring. The MCO Care Coordinator is responsible for providing needed supports for customer direction. The MCO Care Coordinator will assist the customer to choose alternate services and ensure supports are in place for continuity of care, health and welfare during the transition to an agency-based services.

All enrolled waiver customers will be offered the opportunity to direct all, none, or a portion of their services. A waiver customer who selects to direct none or a portion of their services can obtain their waiver services through agency-based service providers.

All waiver customers who select to direct their services using an IP can at any time terminate that choice and transition to an agency-based service provider. In order to assure the customer's health and safety, and to ensure that no interruption of services occur, the MCO will coordinate the transition from self-direction IP services to agency-based service providers.

Voluntary terminations will be recorded on the customer's PCP and will be indicated by the customer's approval of the PCP. Services provided by an IP will only be provided when it has been determined by the HSP Rehabilitation Counselor that the customer can effectively supervise the IP. In cases where the HSP Rehabilitation Counselor determines that the IP cannot meet the needs in the PCP, the customer cannot manage an IP, or the customer's health or safety is at risk, the HSP Rehabilitation Counselor will acquire homemaker services through an agency-based provider. These services will be provided in accordance with the PCP.

For customers enrolled in an MCO, the MCO Care Coordinator will provide the necessary supports to assure continuity of services and customer's health and welfare during the transition.

Services provided by a IP will only be provided when it has been determined by the MCO's Care Coordinator that the customer has the ability to supervise the IP.

In cases where the MCO's Care Coordinator determines that the IP cannot meet the needs of the member outlined in the PCP, or the customer cannot manage a IP (and if the customer has no reliable person available to assist in managing the IP), or the customer's health or safety is at risk by continuing to use a IP, the MCO Care Coordinator will consider the need to terminate the customer directed service involuntarily.

Prior to terminating any customer directed service the MCO Care Coordinator will send the customer a Notice of Action that provides the customer with information as to why their service is being terminated or reduced and includes their rights to an appeal and a fair hearing process.

The MCO Care Coordinator will replace the customer directed service with comparable agency-based services and do so timely to prevent a gap in service or care. Customers maintain the right to choose an agency-based provider in the MCO's contracted provider network. The PCP will be updated to reflect any changes.

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

The MCOs have received initial and ongoing training from the OA regarding customer direction and oversight of IPs. The OA has shared their provider standards with the MCOs that include information on how to determine if the IP can meet the customer's needs. The OA also provides guidance on how to determine when an IP is not meeting needs of the customer and when it is appropriate to change from an IP to an agency-based provider. The Medicaid Agency and OA do not specifically monitor the decisions that are made by the MCO.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Services provided by an Individual Provider (IP) will only be provided when it has been determined by the Home Services Program (HSP) Rehabilitation Counselor that the customer has the ability to supervise the IP. In cases where the HSP Rehabilitation Counselor determines that the IP cannot meet the needs in the Person Centered Plan (PCP), the customer cannot manage an IP, or the customer's health or safety is at risk; the HSP Rehabilitation Counselor will acquire services through an agency-based provider. These services will be provided in accordance with the PCP.

For customers enrolled in an MCO, the MCO Care Coordinator will provide the necessary supports to assure continuity of services and the customer's health and welfare during the transition.

Services provided by an IP will only be provided when it has been determined by the MCO's Care Coordinator that the customer has the ability to supervise the IP.

In cases where the MCO's Care Coordinator determines that the IP cannot meet the needs of the customer outlined in the PCP, or the customer cannot manage an IP (and if the customer has no reliable person available to assist in managing the IP), or the customer's health or safety is at risk by continuing to use an IP, the MCO Care Coordinator will consider the need to terminate the customer directed service involuntarily.

Prior to terminating any customer directed service the MCO Care Coordinator will send the customer a Notice of Action that provides the customer with information as to why their service is being terminated or reduced and includes their rights to an appeal and a fair hearing process.

The MCO Care Coordinator will replace the customer directed service with comparable agency-based services and do so timely to prevent a gap in service or care. Customers maintain the right to choose an agency provider in the MCO's contracted provider network. The customer PCP will be updated to reflect any changes.

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

The MCOs have received initial and ongoing training from the OA regarding customer direction and oversight of IPs. The OA has shared their provider standards with the MCOs that include information on how to determine if the IP can meet the customer's needs. The OA also provides guidance on how to determine when an IP is not meeting a customer's needs and when it is appropriate to change from an IP to an agency-based provider. The Medicaid Agency and OA do not specifically monitor the decisions that are made by the MCO.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	27541	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 2	28367	
Year 3	29217	
Year 4	30094	
Year 5	30998	

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

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

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

If a customer requests that a criminal background check must be completed, the Operating Agency obtains the criminal background check on behalf of the customer and pays all costs associated with acquiring the background check.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to state limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the state's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Eligible customers (or their parent or legal guardian) will be informed of the feasible alternatives available under the waiver at the time they make application for waiver services. The Choice Form is explained to the customer and alternative providers in the area presented in order for the customer to make an informed choice between waiver and institutional services. Customers may consider other potential providers with visits arranged by the HSP Rehabilitation Counselor before they choose services.

For the fee-for-service customers, the fair hearing process is explained to the customer or legal guardian at the time of initial application, upon redetermination for the program, and upon any change in services with which the customer does not agree. Rules for fair hearings are found at 89 Il. Adm. Code, Part 510, Appeals and Hearings, and are summarized throughout this section. Customers enrolled in a Managed Care Organization (MCO) must first file for an internal appeal with the MCO. If the appeal is upheld, customers have the right to request a fair hearing with final decision being made by the Secretary of the Department of Human Services, pursuant to an intergovernmental agreement between the Medicaid Agency and the Operating Agency. The fair hearings process is the same for all customers, including those enrolled with MCOs.

Example of when a customer may request a fair hearing:
- Following refusal by the OA to provide any service it is authorized to provide,
- Modification of any service currently provided to the customer by the OA, termination of a service or case closure, unless agreed to by the customer and the OA,
- Determination that a customer is ineligible for services.

Notice is provided to the customer by the HSP Rehabilitation Counselor for each of the following adverse actions. Waiver services shall be denied or terminated, and case closure can be initiated at any time the customer:
-Refuses services or further services;
-Moves from the State of Illinois or cannot be located or contacted;
-Dies;
-Is institutionalized and not expected to be released for a period to exceed 60 calendar days;
-Is determined to have a projected service cost above that of the projected cost of institutionalization, with the exceptions found at 89 Il. Adm. Code 682.500(a), 682.520, and 684.70(c);
-Has been referred to another agency for the same or similar services and no longer requires or is eligible for HSP services;
-Fails to conduct himself/herself in an appropriate manner (e.g., physical, sexual or repeated verbal abuse by a customer against a DHS employee, provider or agent providing services through the OA; knowingly provides false information; or performs illegal activity that would directly and adversely affect the HSP);
-Is not, or is no longer, at risk of institutionalization due to improvement of his/her condition;
-Fails to meet other eligibility criteria as found at 89 Il. Adm. Code 682 as a result of an initial determination of eligibility or redetermination of eligibility;
-Fails to cooperate (e.g., refuses to complete and sign necessary forms, fails to keep appointments, fails to maintain adequate providers) or
-Cannot have a safe and adequate person centered plan developed for him/her as a result of the original determination of eligibility or redetermination of eligibility.

When an HSP Rehabilitation counselor makes an adverse case decision, the customer will receive a service notice that explains the decision and informs the customer of his/her right to appeal. The service notice is sent to the customer at least 15 days prior to the effective date of the action. The HSP Rehabilitation Counselor is responsible to notify the customer immediately after the decision. If the customer desires assistance during the hearing, he/she may request such assistance from the Home Care Ombudsman Program. Personnel within the Ombudsman program are impartial advocates who assist the customer during the appeal process. The service notice indicates that services will continue until after the hearing officer renders a decision. A copy of the service notice is retained in the case file. When available, a copy of the request for appeal may also be in the service file and will always be maintained in the appeal file under the DHS Division of Hearings and Appeals.

As stated above, customers enrolled in an MCO must first file for an internal appeal with the MCO. If the appeal is upheld, the customer has the right to request a fair hearing with final decision being made by the Secretary of the Department of Human Services. The Medicaid Agency's (MA) fair hearings process is the same for all customers, including those enrolled with MCOs. MCOs are required to have a formally structured appeal system that complies with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. 438 to handle all appeals subject to the provisions of such sections of the Act and C.F.R. (including, without limitation, procedures to ensure expedited decision making when an customer’s health so necessitates and procedures allowing for an external independent review of appeals that are denied by the MCO). The MA reviews and approves the MCO's appeal process guidelines, in compliance with the MCO Contract, Sections 5.30.2.1 and 5.21.1.10.

MCOs inform customers about the fair hearing process in the customer handbook distributed at the time of enrollment (MCO Contract Section 5.21.8.4). Information about the fair hearing process is also published on the MCOs’ websites contained within

the MCO Customer Handbook. Appeal information is also provided whenever a customer requests it. A customer may appoint a guardian, caretaker, relative, or provider to represent the customer throughout the appeal process. The MCO shall provide a form and instructions on how a customer may appoint a representative.

Per 42 CFR 438.402(c) (ii), a customer or an authorized representative, with the customer's written consent, may file an internal appeal. The customer may only initiate a State Fair Hearing after the customer has exhausted the internal appeals process within the MCO. Per 42 CFR 438.406 (a), MCOs are required to help customers in filing an internal appeal or in accessing the fair hearing process including assistance in completing forms and completing other procedural steps. This includes providing interpreter services, translation assistance, assistance to the hearing impaired (including toll-free numbers that have adequate TTY/TTD) and assisting those with limited English proficiency. The MCO must make oral interpretation services available free of charge in all languages to all customers who need assistance. This is also required by the MCO Contract Section 5.21.4.3.

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

Each MCO submits a quarterly Grievance and Appeals summary report to the MA. The format of each report is dictated by the MA (MCO Contract Section 5.30.3.11). The quarterly summary report of Grievances and Appeals filed by customers is organized by categories of medical necessity reviews, access to care, quality of care, transportation, pharmacy, LTSS services and other issues. It includes the total grievance and appeals per 1,000 customers. Additionally, it includes a summary count of any such appeals received during the reporting period, including those that go through fair hearings.

Finally, these reports include Appeals outcomes- whether the appeals were upheld or overturned. Appeals are reported separately for each Waiver. The MA reviews and analyzes the grievance and appeals reports and compares the reports over time and across MCOs to analyze trends, outliers among MCOs and to assure that the MCOs are addressing areas of concern. Records of adverse actions and requests for appeals are maintained by the MCOs for a period of six (6) years, per MCO Contract Section 5.30.4 and Section 9.1.36.

The State ensures that MCO customers are informed by the MCO about their Fair Hearing Process by reviewing and prior approving the Customer Handbook, Notice of Adverse Determination and any Notices of Appeal Resolution letters which must contain the customer's rights to a Fair Hearing and how to request such. The State's External Quality Review Organization (EQRO) also reviews such documents through a desk review and determines if the MCO is compliant during on-site visits. The State reviews/approves the MCO's appeal process guidelines.

The MCO informs the customer about their appeal and fair hearing rights verbally and in writing at the initial face-to-face visit with the customer, at least annually, and as needed. Customers may appeal if services are denied, reduced, suspended, or terminated. In addition, appeals may be made any time the MCO takes an action to deny the service(s) of the customer's choice or the provider(s) of their choice; the appeal process is described in writing in the MCO's customer handbook which is reviewed with the customers by the MCO's Care Coordinator.

When services are denied, reduced, suspended, terminated, or choice is denied, the member is informed via a Notice of Adverse Determination. This notice includes (a) A statement of what action the MCO intends to take; (b) The reasons for the intended action; (c) The guidelines or criteria used in making the decision. The Notice of Adverse Determination also contains information on appealing the determination and how services can continue during the period while the customer's appeal is under consideration. The customer is also informed of the right to request, free of cost, access to all copies of relevant information.

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

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 - this may even occur after the hearing. The informal resolution conference may be requested by contacting the office of which the customer receives services. (Customers Guidance on Rights/Responsibilities/Appeals Procedures; Section 510.100 Informal Resolution Conference.)

Informal resolution offers an opportunity to resolve differences prior to issuance of a final administrative decision. This may take the place of the hearing, if all parties agree on the resolution, but is not required. This is offered as another mechanism through which to address customer's concerns. Informal resolution is conducted by the OA central office staff, and includes the OA Counselor and customer, and other individuals as required, although this is ordinarily kept as informal as possible. If the issues under appeal are resolved according to the satisfaction of all parties, the customer's services will reflect this, the customer will withdraw the appeal, and the OA Division of Administrative Hearings will close the appeal file.

The OA's Division of Administrative Hearings utilizes impartial hearing officers and works with the Home Services Program of the OA to schedule hearings. The hearings are scheduled according to availability of all parties. At least three days prior to the hearing, information submitted by each customer is forwarded to all parties. The hearing officer conducts the hearing. The hearing office will render a decision within 90 days following the hearing. The final administrative decision is made by the DHS Secretary of Human Services. As the single state Medicaid Agency, HFS monitors the Medicaid customer appeal hearing system, including the quality and accuracy of the final decisions made by DHS. DHS Bureau of Hearings and HFS Bureau of Administrative Hearings work in partnership in the implementation of the Intergovernmental Agreement (IGA) goals. The IGA was signed in 2014 and is reviewed annually. Since then, DHS and HFS have a new shared case management system (IES appeals module), which facilitates all the access to number, status, and disposition of Medicaid appeals. DHS and HFS staff members continuously engage in collaborative efforts to maintain the efficiency and to improve the IES appeal module, which contains the data of Medicaid appeals.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

The Department of Human Services, Division of Rehabilitation Services 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 an 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 fee-for-services 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 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 30 calendar days following the date the customer is notified of the action, or 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 they prefer. An explanation of how to file a grievance is included in all customer handbooks. Examples of grievances include complaints about a provider (a provider or staff member did not respect his/her rights), trouble getting an appointment with his/her provider in an appropriate amount of time, or the customer was unhappy with the quality of care of services he/she received. Customers can also file a grievance if an MCO staff person was rude or insensitive about the customer’s cultural needs or other special needs. At any time during the grievance process, the customer can have someone represent or act on the customer’s behalf. The MCO must acknowledge the receipt of the grievance within 48 hours. The MCO has no longer than 90 days to resolve the grievance; the MCO may inform the customer of their decision verbally or in writing.

(b) DRS administration maintains and monitors an unusual incidents database on an ongoing basis. Data is reviewed for analysis, and with DRS administration seeking trends or issues requiring further investigation. Results of this review will be 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 immediately completes an CIR that is disseminated to appropriate DHS administrative personnel. Again, if the issue concerns 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. For instances in which the HSP Rehabilitation Counselor is accused of misconduct, then an 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 an MCO, all grievances shall be registered with the MCO. The MCO’s procedures must: (i) be submitted to the MA in writing and approved in writing by the MA (MCO Contract Section 5.30.1.1); (ii) provide for prompt resolution, (MCO Contract Section 5.30.1.2) and (iii) assure the participation of individuals with authority have no previous involvement of review, and provide appropriate clinical expertise to require corrective action (MCO Contract Section 5.30.1.4) . The MCO must have a Grievance Committee for reviewing grievances registered by its customers (MCO Contract Section 5.40.6). MCO customers must be represented on the Grievance Committee.

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

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

-The Grievance Committee must have at least one (1) customer on the Committee.
-A summary of all Grievances heard by the Grievance Committee, as well as the responses and disposition of those matters must be submitted to the MA quarterly; and

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

DRS administration is responsible for ensuring that all Critical Incident Reports (CIR) are processed 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 Counselor is 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 in order to ensure proper resolution. As a result, a high level of interaction is maintained on an ongoing basis by administrative and field staff.

Customers under the age of eighteen:

The Abused and Neglected Child Reporting Act – ANCRA (325 ILCS 5) sets forth the requirements for reporting and responding to situations of abuse and neglect against children under the age of 18.

The types of Critical Incidents (CIs) that must be reported include any specific incident of abuse or neglect or a specific set of circumstances involving suspected abuse or neglect, where there is demonstrated harm to the child or a substantial risk of physical or sexual injury to the child. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

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

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

DCFS Hotline Numbers:
1-800-25-ABUSE or 1-800-252-2873 (voice)
1-800-358-5117 (TTY)

Customers age 18 and older

Adult Protective Services (APS)

The processes defined under Adult Protective Services (APS) are the same whether the waiver customer receives care coordination through the state or through managed care.

Public Act 94-1064 amended the Elder Abuse and Neglect Act, changing the name of the entity to Adult Protective Services which had the effect of expanding the former Elder Abuse program to include adults with disabilities (age 18 and older) and adults that are over age 60. In addition, the Adult Protective Services Act (320 ILCS 20/1 et seq.) authorized the Illinois Department on Aging (IDoA) to administer the Adult Protective Services unit (APS) to respond to reports of abuse for all non-institutionalized adults that meet this criteria. The empowered APS unit provides investigation of allegations and intervention and follow-up services to victims. It is coordinated through contracted agencies located throughout the state and designated by the Area Agencies on Aging (AAA) and Illinois Department on Aging (IDoA). The APS agencies conduct investigations, establish substantiation decisions, develop plans to mitigate the abuse and provide continued monitoring of cases of allegations of abuse. Customers can report suspected abuse, neglect or exploitation to IDoA by utilizing the APS Hotline number at 1-866-800-1409, available 24 hours a day, seven days a

week.

Definitions of Abuse, Neglect and Exploitation (ANE)

The definition of abuse pertains to Illinois residents living in a domestic setting who are over 18 years and have a disability or any adult age 60 years or older. The abuse must be one of the following types and must be committed by another person.

The State uses a set of definitions for CIs covering abuse, neglect, exploitation and other events that can place an adult at risk. These definitions can be found at 89 ILAC Section 270.210.

The APS responds to the following types of abuse:
- Physical abuse means inflicting physical pain or injury upon an adult
- Sexual abuse means touching, fondling, intercourse, or any other sexual activity with an adult, when the adult is unable to understand, unwilling to consent, threatened or physically forced.
- Emotional abuse means verbal assaults, threats of maltreatment, harassment or intimidation.
- Confinement means restraining or isolating an adult, other than for medical reasons.
- Passive neglect means the caregiver's failure to provide an adult with life's necessities, including, but not limited to, food, clothing, shelter or medical care.
- Willful neglect or deprivation means deliberate denial of an adult medication, medical care, shelter, food, a therapeutic device, or other physical assistance and thereby exposing that person to the risk of physical, mental or emotional harm- except when the adult has expressed capacity to understand the consequences and intent to forego such care.
- Financial exploitation means the misuse or withholding of an adult's resources by another to the disadvantage of the adult person, or for the profit or advantage of someone else.

A substantiated case means a reported case of alleged or suspected abuse, neglect, financial exploitation, or self-neglect in which an APS agency, after assessment, determines that there is reason to believe abuse, neglect, or financial exploitation has occurred.

State regulations covering APS, mandated reporting, and timelines are contained in 89 Illinois Administrative Code (ILAC), Part 270.

Reporting

More information and brochures [Adult Protective Services Act and Related Laws and What Professionals Need to Know] may be found at: http://www.illinois.gov/aging/ProtectionAdvocacy/Pages/abuse.aspx

Mandated Reporters

The Illinois Adult Protective Services Act (320 ILCS 20/1) requires personnel of the Operating Agency (OA) and Managed Care Organizations (MCOs) to be mandated reporters in all cases of suspected or alleged abuse and/or neglect of a child, adult or elder, as the abuse and/or neglect becomes known to the employee in his or her professional or official capacity. Staff are mandated to personally report the allegations of abuse, neglect and financial exploitation to APS within 24 hours. IDoA's Office of Adult Protective Services maintains a tracking system of ANE investigations and statistical reports are generated annually. Mandated Reporting and timelines for reporting can be found at: 89 ILAC, Section 270.230.

Reporting Timelines

Follow-up Actions by IDoA can be found at: 89 ILAC, Section 270.240 Intake of ANE Reports
Rules may be accessed at IDoA's website at:
http://www.illinois.gov/aging/AboutUs/Pages/rules-main.aspx

When OA staff is made aware of any allegations of Abuse, Neglect or Financial Exploitation, they must take the following actions:

1. Report the suspected abuse, neglect or financial exploitation to the APS by calling the statewide 24-hour APS Hotline at 1-866-800-1409, 1-888-206-1327 (TTY)
2. Alert local authorities, if necessary.
3. Complete a Critical Incident (CI) Report in the Case Management System, including a concise summary of the incident, including significant customers and their relationships.
4. Home Services Program (HSP) Rehabilitation Counselors and Supervisors must be informed immediately of any APS report received and CI Report submitted, so everyone is aware of the incident.

When notified of an APS investigation, the OA's Central Support office enters information into a database for abuse, neglect, incidents, and complaints. The OA's Central Support notifies appropriate field staff, and monitors field activity. Should the allegation be substantiated, the field office is notified, and appropriate action is taken.

Other CIs including those resulting in death or injury not related to ANE:

If the OA Rehabilitation Counselors are made aware of the incidents, they are reported to the central office and an OA Rehabilitation Counselor is assigned to the case. OA Rehabilitation Counselors assist with reporting and remain involved in the case to ensure the customer is safe from harm and that an adequate Person Centered Plan (PCP) is in place to address the customer's needs.

Reports may be generated by the OA that can be tailored to meet specific data needs. Information gathered on the database includes customer demographic data, alleged perpetrator information, incidents of alleged or substantiated abuse and neglect, involvement from the Office of Inspector General or the IDoA, action taken by the OA, and outcome information. These reports are shared on a quarterly basis with the MA.

For participants enrolled in an MCO, the MCOs will have processes and procedures in place to receive reports of CIs. The MCOs shall comply with the Department of Human Services Act (20 ILCS 1305/1-17), the Adults with Disabilities Domestic Abuse Intervention Act (20 ILCS 2435), Elder Abuse and Neglect Act (320 ILCS 20/1) and the Abused and Neglected Child Reporting Act (325 ILCS 5/4). The MCO shall have a formal process for reporting incidents that may indicate abuse, neglect or exploitation of a customer.

The MCOs must comply with the OA's critical incident reporting requirements.

Examples of critical events may include but are not limited to:
• Death
• Falls
• Serious physical injury or abuse
• Hospital admission
• Misuse of funds
• Medication error
• Unauthorized use of restraint, seclusion or restrictive physical or chemical restraints
• Elopement or missing person
• Fires
• Possession of firearms (customer or staff)
• Criminal victimization
• Financial exploitation
• Suicide or attempted suicide

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

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

The MCOs will continue to provide the customer, or their family or representatives, information about their rights and protections, including how they can safely report an event and receive the necessary intervention or support.

Also, the MCOs will assure that HCBS waiver agencies, vendors and workers (including Care Coordinators) are well informed of their responsibilities to identify and report all CIs. Responsibilities are also re-enforced through periodic training.

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

Upon initial eligibility determination, and subsequent redetermination of eligibility, customers are informed of their rights and responsibilities, including their right to be free from abuse, neglect, and exploitation. Information is shared on whom to notify if abuse, neglect or exploitation occurs. All waiver customers must review and sign the Home Services Program (HSP) Application and Redetermination of Eligibility Agreement. The contents of this document are thoroughly explained to the customer.

As indicated above, customers have discussions about abuse, neglect, and exploitation with the Operating Agency (OA) HSP Rehabilitation Counseling staff at initial enrollment and annual redetermination.

Training specific to abuse, neglect and exploitation is not provided, but the OA does educate customers on those topics. At the time of application and at each redetermination of eligibility, the HSP Rehabilitation Counselors inform customers of their right to be free from abuse, neglect and exploitation and whom to contact for help or to report concerning activity. All waiver customers must review and sign the HSP Application and Redetermination of Eligibility Agreement which contains necessary information about reporting abuse, neglect and exploitation. The contents of this document are thoroughly explained to the customer.

MCOs must comply the Abused and Neglected Child Reporting Act, the Elder Abuse and Neglect Act and the Critical Incident reporting requirements of the OA. MCOs must comply with all health, safety, and welfare monitoring and reporting required by State or federal statute or regulation, or that is a condition for a HCBS Waiver, including the following: critical-incident reporting regarding abuse, neglect, and exploitation; critical-incident reporting regarding any incident that has the potential to place a customer, or a customer's services, at risk, but which does not rise to the level of abuse, neglect, or exploitation; and performance measures relating to the areas of health, safety, and welfare and required for operating and maintaining an HCBS Waiver.

Through an ongoing basis, the MCO must identify, address, and seek to prevent the occurrence of abuse, neglect, and exploitation. Performance Measures regarding health, safety, welfare, and critical-incident reporting are included in the MA contract. Customers are provided information about how and to whom to report abuse, neglect and exploitation during assessments and reassessments. This happens at least quarterly, during face-to-face assessments.

The MCO must train all of their external-facing employees on ANE and critical incidents. This includes network provider and subcontractors, who must be able to recognize potential concerns related to abuse, neglect, and exploitation. MCOs must also train those entities on their responsibility to report suspected or alleged abuse, neglect, or exploitation. MCOs train entities at outset on these subjects, can retrain when necessary, and post all material online for providers to review. Online material includes how to report ANE to appropriate authorities. MCOs train members, and family members about the signs of ANE and what to do if they suspect ANE. Training sessions are customized to the target audience. Trainings include general indicators of ANE and the time-frame requirements for reporting suspected ANE.

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

For customers under the age of 18:

The Department of Children and Family Services (DCFS) is the state agency that is responsible for conducting investigations of child maltreatment and arranging for needed services or protective plan as appropriate, for children and families where credible evidence of abuse or neglect exists. DCFS provides protective services at the request of the subjects of the report, even when the report has been unfounded.

DCFS field office staff are required to make initial contact and start the investigation of the allegation within 24 hours of the hotline report. If there is a possibility that the family may flee or if the immediate well-being of the child is endangered, an investigation will start immediately.

Most investigations are conducted in 60 days unless there is just cause for a 30 day extension in order to make a determination whether the allegation is indicated or unfounded. Appropriate emergency services are provided while the investigation is pending. Emergency and ongoing services may include safety plans, protective plans, family support or protective custody, which places the child in substitute care.

Serious allegations such as sexual abuse, serious physical harm, or death are reported to the local law enforcement agency, the State's Attorney, and to the Child Advocacy Center, if available, as a coordinated approach to the investigation. The approach includes victim sensitive interviewing of the alleged child victim(s) and identification and prosecution for a criminal act. DCFS uses a Child Endangerment Risk Assessment Protocol (CERAP) to assess safety of the child. The interview process includes an assessment of the alleged victim’s immediate safety. Safety plans can include voluntary removal of the alleged perpetrator or of the alleged victim. If the family refuses to establish a safety plan to control for the threats of danger to the alleged victims, then the child is removed. DCFS staff conduct face-to-face monitoring and reassessment every five days until the child is determined to be safe in the home.

A protective plan is enforced in out-of-home settings, such as daycares and residential settings. The protective plan restricts accessibility of the perpetrator to the child, and it stays in place until the investigation is completed. If the investigation determines that an abuse or neglect situation is indicated, license revocation or remediation activities begin. Monitoring is conducted weekly by investigators and licensing staff until resolved.

If a finding is indicated, the perpetrator's name is placed on the DCFS State Central Register for a minimum of five years, 20 years if there was serious physical injury, and 50 years in cases of sexual penetration or death. If a finding is unfounded, the name is on the DCFS State Central Register for a minimum of 30 days up to three years depending on the seriousness of the situation.

Customers Age 18 and Older:

Adult Protective Services (APS), operated under the Illinois Department on Aging (IDoA), receive and investigate all reports of Critical Incidents (CIs) that involve Abuse, Neglect and Exploitation (ANE). Customers, family members and others may call the State’s Senior Helpline: 1-800-252-8966 or the 24-Hour Adult Protective Services Hotline at 1-866-800-1409 to report an allegation of ANE.

The HSP Rehabilitation Counselor, the Operating Agency (OA) and the Managed Care Organization (if customer is enrolled in an MCO)are notified of incidents via a Report of Substantiation produced by APS. Depending on the nature of the incident of ANE, the customer and/or family members, and providers may be notified. The State has set criteria regarding when notifications are mandatory or when they are at the discretion of the HSP Rehabilitation Counselor.

IDoA has established classifications for critical incidents (i.e., Priority I, II, III,) depending upon the nature and urgency of the event. This classification determines whether an investigation needs to occur in the timeframe for conducting that investigation. The definitions and time frames of these levels are located at 89 ILAC Section 270.240

Responding to Reports –
Depending on the nature and seriousness of the allegations, a trained APS caseworker makes a face-to-face contact with the alleged victim within the following time frames:

•Priority One – Reports of abuse or neglect where the alleged victim is reported to be in imminent danger of death or serious physical harm. The caseworker must make a face-to-face visit within 24 hours.

•Priority Two – Reports that an alleged victim is being abused, neglected, or financially exploited and the report taker has reason to believe that the health and safety consequences to the alleged victim are less serious that priority one reports. The caseworker must make a face-to-face visit within 72 hours.

•Priority Three – Reports that an alleged victim is being emotionally abused or the alleged victim's financial resources are being misused or withheld and the report taker has reason to believe that there is no immediate or serious threat of harm to the alleged victim. The caseworker must make a face-to-face visit within 7 calendar days of the receipt of the report.

The APS requires that all Priority I incidents be at least temporarily corrected within 24 hours and a permanent correction must occur within 60 days. All other events must be corrected within 60 days. The State's Office of Adult Protective Services' regulations also require certain response timelines by the ANE agency. These are located at 89 ILAC Part 270.

The Event Reporting system within the OA tracks the status of any investigation and follow-up actions taken. The State has established criteria regarding when the HSP Rehabilitation Counselor must conduct a review, when an on-site visit must occur, and when the change of status redetermination must occur.

NOTE: the MCO contract does not dictate when a review or onsite must occur when a CI has been substantiated. The contract does indicate that the MCO will comply with the decision APS has made and will take appropriate action for the customer within the timeframe APS has given. Per APS policy, once a case has been substantiated and the customer agrees to APS services, the MCO Care Coordinator will consult with APS within 20 calendar days. Within that time, the MCO will work with both APS and the customer, review and, if applicable, update the current person-centered care plan to reflect customer needs.

MCOs maintain an internal reporting system for tracking, reporting, and responding to Critical Incidents and for analyzing an event to determine what changes are needed.

The state is responsible to ensure the health and welfare of the customer and may authorize additional services to protect the welfare of the customer. The APS case worker will contact the victim and work with the OA or the MCO care coordinator to help determine what services are most appropriate to stop the abuse, neglect, or financial exploitation. Those services may include:

- in–home or other health care;
- nutrition services;
- adult day services;
- respite care for the caregiver;
- housing assistance;
- financial or legal assistance and protections, such as representative payee, direct deposit, trusts, order of protection, civil suit or criminal charges;
- counseling referral for the victim and the abuser;
- when needed, guardianship proceedings or long-term care placement;
- emergency responses for housing, food, physical and mental health services.

The MCOs are expected to provide any services that APS recommends that fall within MC coverage, and refer for services outside MC coverage (housing assistance, for example).

CIs may also result in a review of the customer's needs to determine whether a change in the service or level of service is needed. A determination may also be made on whether intensive care coordination is needed. MCOs must follow up on Critical Incident outside those determined ANE to ensure information was reviewed and corrective measures were taken. Resolution or remediation is based on the nature of the concern. MCOs must submit a Critical Incident Detail Report (sent monthly) and a Critical Incident Summary report (sent quarterly) to HFS; Critical Incidents for the HCBS waiver population are broken out by waiver population.

APS Reporting

State requirements for reporting of abuse, neglect or financial exploitation of customers age 60 years and older are as follows:

The OA's Office of Adult Protective Services administers the ANE Program, which responds to alleged abuse, neglect or financial exploitation of persons 60 years of age and older who reside in the community. The program provides investigation, intervention and follow-up services to victims. It is locally coordinated through contracted statewide agencies designated by the Area Agencies on Aging (AAA) and IDoA. The APS agencies conduct investigations and work with older adults in resolving abusive situations.

Abuse Hotline Number:

866-800-1409 (voice): available 24 hours a day, seven days a week
888-206-1327 (TTY)
Senior HelpLine number, 1-800-252-8966, during regular business hours. After-hour and weekend calls are automatically transferred to the Abuse Hotline number.

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

Immediately upon receipt of the Notification of Investigation from the Adult Protective Service (APS), the Operating Agency (OA) Fraud Unit forwards the notice to the appropriate OA field office for follow up. The OA Fraud Unit maintains a database in order to track response by the field office.

Critical Incident (CI) Reporting is now completed electronically. Critical Incident (CI) Reports should be completed for situations that are unusual in nature. These include, but are not limited to customer incidents, staff/customer related incidents, and Individual Provider (IP)/customer issues. All OA CIs Reports are entered on WebCM, the virtual case management system, as soon as the OA staff becomes aware of an issue. CI issues may require additional follow up by e-mail or telephone call. The purpose of the CI Report is to alert the chain of command, up to and including the OA Director, promptly of issues such as those listed above so his/her office can quickly alert the OA Secretary and immediate staff about issues. CI reports are reviewed and discussed by the Medicaid Agency (MA) and OA at quarterly Quality Assurance meetings.

Reports are completed the same day of the incident. All reports are reviewed daily and distributed to the appropriate source for follow up. Follow up may be on the specific incident only or may require alerts or directions to all Home Services Program (HSP) staff for program wide changes aimed at preventing reoccurrence. As statutorily mandated reporters, OA staff are also required to refer all incidents regarding abuse, neglect and/or financial exploitation to the statewide 24-hour Adult Protective Services Hotline. The OA will follow up with the field staff on all reports which deal with abuse, neglect or financial exploitation." If an incident involves someone under the age of 18, the Department of Children and Family Services is contacted.

In addition, the OA Fraud Unit works with the local OA field office staff to ensure proper resolution. Critical Incidents are monitored by HSP administration on an ongoing basis. Data is reviewed for analysis and to determine if there are any trends or issues requiring further investigation.

The APS Unit shall initiate an assessment of all reports of alleged or suspected abuse or neglect within 7 calendar days after the report. Reports of exploitation shall be assessed within 30 calendar days after the report is received. Reports of abuse or neglect that indicate that the life or safety of an adult with disabilities is in imminent danger shall be assessed within 24 hours after the receipt of the report. When the APS determines that a case is substantiated, it shall refer the case to the appropriate OA’s office or to the appropriate Managed Care Organization (MCO) to develop, with the consent of and in consultation with the adult with disabilities, a Person Centered Plan (PCP) to address the person’s needs.

The OA Fraud Unit contacts appropriate field personnel to request follow up on an allegation and request an update on attempts to resolve the situation. Field personnel indicate whether or not an internal investigative review has been completed and the results of that review; and/or if external agencies were contacted for assistance such as the Office of Inspector General, the local police, the DHS Divisions of Mental Health or Developmental Disabilities, etc. All information gathered from these sources is entered into the Critical Incident portion of the customer’s case within WebCM.

All information is gathered and stored in the customer's case file, including written, faxed, e-mailed information, case notes, etc. In addition, CI reports are submitted by the field, with intake and final reports from the APS being entered into the OA’s Critical Incident database. This information is confidential and is retained for monitoring purposes. The data is reviewed to determine if there are trends or patterns, and if there are situations that need additional investigation or follow up. When warranted, further investigation is pursued. Information stored in the database helps to prevent recurrence of incidents involving the same customer and an alleged offender.

Additionally, the database is used as a reference for investigation of grievances, unemployment claims, and fraud allegations. Together field personnel, administration, APS, and the OA Fraud Unit work together to resolve and prevent the incidence of ANE. These activities are completed on an ongoing basis, and investigation is not complete until resolved by the APS.

For customers enrolled in an MCO, the MCOs will maintain an internal reporting system for tracking the reporting and response to CIs. CI reporting will be included in the reporting requirements to the MA. The MA monitors both compliance of performance measures and timeliness of remediation for those waiver customers enrolled in an MCO. Customers in MCOs are included in the representative sampling.

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of restraints**

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

The State does not authorize the use of restraint or seclusion in the waiver program. Any allegations of restraint, seclusion, or other potential abuse, neglect, or financial exploitation would be reported to Operating Agency administration via the unusual incident report procedure. Simultateously, an alleged incident would be reported to the proper authority for review.

For customers enrolled in an Managed Care Organization (MCO), the MCOs are responsible to detect the unauthorized use of restraint or seclusion. Events involving the use of restraint or seclusion would be reported to the MCO as a reportable incident, and reported to the investigating authority as indicated.

The OAs and MCOs detect the use of restraints through face-to-face visits and routine contacts with the customer, and through reports by providers, family, or friends—as well as through the analysis of complaints or incidents. The Home Services Program Rehabilitation Counselors or MCO Care Coordinators are responsible for overseeing waiver customers and assuring their health, safety, and welfare.

(See Appendix G-1 for information about critical event or incident reporting requirements.)

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

The State does not authorize the use of restrictive interventions in the waiver program. Any allegations of restrictive interventions or potential abuse, neglect, or financial exploitation would be reported to the Operating Agency (OA) administration via the Unusual Incident Report procedures. Simultaneously, an alleged incident would be reported to the proper authority for review: the Department of Children and Family Services or the Adult Protective Service Unit of the Illinois Department on Aging.

For customers enrolled in an Managed Care Organization (MCO), the MCOs are responsible to detect the unauthorized use of restrictive interventions. Events involving the use of restrictive interventions would be reported to the MCO as a reportable incident, and reported to the investigating authority as indicated.

(See Appendix G-1 for information about critical event or incident reporting requirements.)

The MCOs and OA detect the unauthorized use of restrictive interventions through face-to-face visits and routine contacts with the customer, and through reports by providers, family, or friends—as well as through the analysis of complaints or incidents. The Home Services Program Rehabilitation Counselors or MCO Care Coordinators are responsible for overseeing waiver customers and assuring their health, safety, and welfare.

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

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

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

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of seclusion**

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

The Home Services Program Rehabilitation Counselors and the Managed Care Organization Care Coordinators through their regular contact monitor for all activities that appear to fall under abuse, neglect and exploitation. Seclusion would fall under this category. In addition, all providers are trained to monitor similar activities. Reports of abuse, neglect and exploitation, including seclusion are to be made to the Adult Protective Services Unit for investigation.

The MCOs and OA detect the use of seclusion through face-to-face visits and routine contacts with the customer, and through reports by providers, family, or friends—as well as through the analysis of complaints or incidents. The Home Services Program Rehabilitation Counselors or MCO Care Coordinators are responsible for overseeing waiver customers and assuring their health, safety, and welfare.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

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 States quality improvement strategy, provide information in the following fields to detail the States 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: Number and percent of records where the customer/representative received info from the OA/MCO about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. N: # of records where the customer/rep received info from the OA/MCO about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. D: Total # of records reviewed

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
G2:# and % of unexplained deaths and substantiated incidents of A/N/E reported to the OA and MCO that were reviewed/investigated within the req. timeframe N: # of unexplained deaths and substantiated incidents of A/N/E reported to the OA and MCO that were reviewed/investigated within the req. timeframe D: Total # of unexplained deaths and substantiated incidents of A/N/E reported to the OA and MCO

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G3: # and % of deaths related to a substantiated case of abuse or neglect reported to the OA and MCO where approp. actions were taken to address incident N: # of deaths related to a substantiated case of abuse or neglect reported to the OA and MCO where approp. actions were taken to address incident D: Total # of deaths related to a substantiated case of abuse or neglect reported to the OA and MCO

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; OA Reports, APS Substantiated Incidents, DCFS reports

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
G5: # and % of substantiated incidents of confinement (restraint or seclusion [R&S]) reported to the OA and MCO where appropriate actions were taken to address the incident. N: # of substantiated incidents of confinement (R&S) reported to the OA and MCO where appropriate actions were taken to address the incident. D: # of substantiated incidents of confinement (R&S) reported to the OA and MCO.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports, MCO Reports, APS/DCFS Substantiated Incidents

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

Data Aggregation and Analysis:

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

Performance Measure:
G6: Number and percent Individual Providers who received training on alternative practices to restrictive interventions, including restraints and seclusion. N: Number of Individual Providers who received training on alternative practices to restrictive interventions, including restraints and seclusion. D: Total number of Individual Providers.

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

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
G7: Number and percent of customer survey respondents who reported to the OA and MCO of being treated well by direct support staff. N: Number of customer survey respondents who reported to the OA and MCO of being treated well by direct support staff. D: Total number of OA and MCO customer survey respondents.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G8: Number and percent of customers reporting that they visited a doctor or practitioner for an annual screening within the last 12 months. N: Number of customers reporting that they visited a doctor or practitioner for an annual screening within the last 12 months. D: Total number of customer records reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a +/- 5% margin of error. The MA will pull the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports. For critical incidents, the MCOs are required to report 100% of the findings and remediation. These reports will be summarized by the MCOs and reported at least quarterly to the MA.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 30 days.

G2: The OA/MCO will follow up on unexplained deaths and outstanding Adult Protective Service (APS) referrals and DCFS reports of substantiated incidents. Changes in customer's Person Centered Plan (PCP), corrective action plans, or provider sanctions will be made when needed. Remediation must be completed within 30 days.

G3: The cause of death/circumstances would be reviewed by the OA and MCO and need for training or other remediation, including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns. Resolution or remediation timeframe would be case-specific.

G4: The OA/MCO will review all outstanding critical incidents with the MA to identify trends and implement systemic interventions, which may include training, a plan of correction, or other remediation to assure that critical incidents are being analyzed to determine root cause. Remediation must be completed within 30 days.

G5: The OA/MCO will follow up on all outstanding APS referrals and DCFS reports of substantiated incidents where restrictive interventions were used. Changes in customer's PCP, corrective action plans, or provider sanctions will be made when needed. Remediation must be completed within 30 days.
G6: The OA will follow up to ensure the individual provider receives training on alternative practices to restrictive interventions, including restraints and seclusion, within 30 days.

G7: If identifying information is available for customer surveys, the HSP Rehabilitation Counselor, BI Case Manager, or the MCO Care Coordinator will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Patterns of negative responses, including anonymous survey responses, will be used to identify need for system improvement.

G8: During the initial evaluation or redetermination, the HSP Rehabilitation Counselor or the MCO Care Coordinator will ask whether the customer has a primary care doctor or practitioner and whether the customer had a physical in the last 12 months. If not, barriers will be identified and addressed. Remediation will occur at the meeting between the customer and HSP Rehabilitation counselor or the MCO Care Coordinator.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency (MA), the Illinois Department of Human Services, Division of Rehabilitation Services (DHS-DRS), as the Operating Agency (OA), and the contracted Managed Care Organizations (MCOs) work in partnership to evaluate the waiver Quality Management System (QMS). This partnership provides analysis to information derived from discovery and collaboratively develops and monitors remediation activities for each of the federal assurances.

The MA, OA, and MCO's are responsible for data collection and remediation activities. The OA is solely responsible for eligibility and authorizing qualified providers. Therefore, there are distinct performance measures for these functions under the OA. Both the OA and the MCOs are accountable for all other measures. The MA is accountable for the measures in the Administrative Authority appendix. The State's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the waiver performance measures.

The persons with disabilities waiver Quality Management System (QMS) plan is part of an overall quality management plan for the three 1915 (c) waivers operated by the DHS-DRS (OA). The other waivers include the HIV/ AIDS Waiver (control number IL.0202), and the Brain Injury Waiver(control number IL.0329). While some data may be collected during the same on-site provider and case manager reviews, the sample for each waiver is drawn separately and the results are aggregated separately.

The MA's ongoing quality monitoring includes sharing of reports from QIO reviews with the OA as well and review site, and EQRO reviews with the OA and the MCO.

On a quarterly basis, the MA conducts separate Quality Management Committee (QMC) meetings with the OA and the MCOs to review data collected from the previous quarter and for the year to date. Data is collected on a regular basis and reported as indicated by the performance measures in the waiver.

OA and MCO compliance data is reported by individual performance measures. Data reported includes level of compliance and timeliness of remediation based on immediate, 30, 60, 90 day increments and any outstanding remediation.

During quarterly meetings, the MA, and the OA or MCO will identify trends based on scope, severity, changes, and patterns of compliance by reviewing both the levels of compliance with the performance measures and remediation activities conducted by the OA and the MCOs. Identified trends are discussed and analyzed regarding cause, contributing factors, and opportunities for system improvement. Systems improvement is prioritized based on the overall impact to the participants and the program. Systems improvements may be prioritized based on factors such as: the impact on the health and welfare of waiver participants, legislative considerations, and fiscal considerations. The OA and the MCOs maintain separate QMC Systems Improvement Logs. Recommendations for system improvements are added to the log(s) for tracking purposes. The OA and the MCOs document the systems improvement implementation activities on their respective logs. The MA assures that the recommendations are followed through to completion. Decisions and timelines for system improvement are based on consensus of priority and specific steps needed to accomplish change. These decisions are documented on the systems improvement log and will be communicated through the sharing of the quarterly meeting summary and the systems improvement log.

The MA hosts weekly operational meetings with the MCOs. All MCOs are required to attend. Subject matter is based on MCO need or when the MA has identified a need to review.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

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

The processes Illinois follows to continuously evaluate, as appropriate, effectiveness of the QMS are the same as the processes to evaluate the information derived from discovery and remediation activities. The Waiver Quality Management Committee (QMC) System Improvement Log is a dynamic product that is discussed quarterly by key staff of the MA and the OA or MCO regarding progress, updates, and evaluation of effectiveness. Effectiveness is measured by impact on performance based on ongoing data collection over time, feedback from customer/guardian interviews, satisfaction surveys, and service providers. Multiple years of data collection will allow the MA to evaluate the effectiveness of system improvements over time.

System design changes may be specific to the OA, the MCOs, or both. Meeting with all parties annually provides an arena to see the system holistically and determine how well the system design changes are working and what areas need further improvement. Decisions that are made as a result of these meetings will be tracked on the QMC Systems Improvement Log.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

One QMC meeting a year is a combined meeting where the MA, the OA, and the MCOs meet and discuss statewide issues impacting the waiver. During this annual meeting, the OA and the MCOs will provide an overview of the previous year’s activities and a discussion of whether changes are needed to the Quality Management Strategy. There will be five primary focus areas: These areas are described below.
1) Structure of the QMC: The group reviews the structure of the QMC to determine if it is effective.
2) Trend Analysis: The group will evaluate the processes for identifying trends and patterns to assure that issues are being identified.
3) Systems Improvement Log: The group reviews the QMC Systems Improvement Log to assure that all recommendations have been implemented in accordance with agreed upon timelines, and if not, whether there is justification.
4) System Improvement Priorities: The methods for determining system improvement priorities is evaluated to determine its effectiveness.
5) Performance Measures: The entities will determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures will also be reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

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

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

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

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

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

Requirements concerning the independent audit of provider agencies:

Department of Human Services, Division of Rehabilitation Services (DHS/DRS) completes a review of each Homemaker and Adult Day Service provider at a minimum of every two years to ensure compliance with program regulations. The compliance review is conducted on all agencies currently enrolled with DHS/DRS for the purpose of determining compliance and/or continued compliance with the Administrative Code: Title 89: Social Services, Chapter IV: Department of Human Services, Subchapter d: Home Services Program, Part 686 Provider Requirements, Type Services, and Rates of Payment. Homemaker and Adult Day Service Agencies are required to engage an independent certified public accounting agency complete an independent audit of their financial statements, and to verify the accuracy of information and data submitted to the OA. This audit will be performed at the Homemaker Agency provider agency's expense.

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

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

ii. On one of these two forms, the Individual Provider Payment Policies, the IP must assure that he or she will provide services in accordance with the customer Person Centered Plan (PCP) which specifies the frequency, amount, and duration of services to be provided. This form also requires the IP to assure that he or she will abide by the limits of service provision as also specified in this section of the Administrative Code.

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

At the time of redetermination, there is a visual review of the customer's physical condition and home environment for evidence that the tasks to be performed by the customer's IP have been performed, as well as an interview with the customer regarding his or her satisfaction with their IP using the annual IP Evaluation form.

The waiver also has more systematic ways to check for fraud as it relates to service provision by IPs. For example, the program receives monthly reports which show that IPs may have provided services when a customer was in the hospital or nursing home or after a customer's death. Any indication that the IP is not providing the correct hours of service and performing the correct tasks for eligible customers are followed up on promptly. Any inappropriate payments must be repaid and backed off the Medicaid claim. In addition, where there is indication that IPs have sought inappropriate payments, the OA takes corrective actions up to and including preventing the IP from providing any future services in the program.

Agency scrutiny is triggered in several situations, including where there are complaints about no-show homemakers and when IPs bill for more services than are on the PCP. In addition, agency scrutiny is triggered based on reports the OA gets on totals paid to the agencies. If the reports do not match the information being sent by agency administration, the OA knows that the information may be inaccurate. The OA has also noted instances in which agencies have tried double and triple billing for the same month or for the same customer, or when agency bills contain customers that are no longer being served or perhaps were never served. These billings are additional examples of evidence suggesting fraudulent information.

The OA requires independent annual audits in compliance with DHS Administrative Codes Section 686.100 Adult Day Service (ADS) Provider Requirements and Section 686.250 Financial Reporting of Homemaker Service Providers. Adult Day Service and Homemaker providers must provide the licensing agency, Illinois Department on Aging, with an annual audit report to be completed by an independent Certified Public Accountant (CPA) and in accordance with 74 Ill. Adm. Code 420.Subpart D. The audit report shall be filed at the main office of the Illinois Department on Aging, Springfield, Illinois, within 6 months after the date of the close of the provider's business fiscal year. The OA obtains these reports

directly from the provider. The OA and the licensing agency, IDoA, also communicates when there are provider compliance issues. A special review may be conducted based on these communications.

The OA also reviews fiscal activity on customer cases as part of the OA overall quality assurance process. Every two years the OA conducts a compliance review of the provider and reviews certain criteria regarding fiscal accountability. All providers are reviewed within the two-year cycle and all reviews are conducted onsite. The review process is the same for both adult day service and homemaker providers. Prior to the compliance review, the OA conducts a preliminary record review to identify red flags. If issues are found, those cases are pulled and reviewed onsite. Examples of red flags include inconsistent attendance or no attendance by customer with conflicting billing data; and billing more than what was authorized by the OA. The number of cases reviewed may vary depending on the number of customers served by the provider. The OA methodology uses a floor of ten cases. If the provider serves fewer than ten customers, all records are reviewed. If more than ten, a 10% random record review is selected with the floor of ten. The period reviewed is based on the previous fiscal year. Lastly, to ensure proper identification of customers and providers, all customers social security numbers are verified for accuracy through the Social Security Administration database, and all providers' employer identification numbers are likewise verified prior to enrollment as a Medicaid provider.

(b) The financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits;

The Medicaid Agency (MA) has implemented oversight procedures that provide assurance that claims are coded and paid in accordance with the reimbursement methodology specified in the waiver. These processes enable staff to monitor the financial aspects of the Persons with Disabilities waiver from a global perspective, rather than review a sample of paid claims. The MA determined that reviewing a sample of paid claims was of limited effectiveness and would not likely disclose problematic billings, patterns and/or trends.

The State has mechanisms in both the MA and OA to recognize whether a provider is a certified biller. The MA has an elaborate IT system which records whether the provider documentation has been received and reviewed and for what period of time the certification is valid. This information then becomes an IT edit for all subsequent financial transactions for this provider for the period that the certification is valid. At the expiration date, no further payments or claims can be made by the MA for this provider until recertification is completed and recorded on the IT system.

The OA has an equally elaborate IT recording and edit system. The MA's certification is also recorded in the OA system along with the OA's own required enrollment information. The OA's EVV timekeeping and billing system for IPs will not take recorded start and stop times until the IP has completed all enrollment information for both the MA and the OA. Without that information, IPs cannot be paid. The fee schedule is posted at http://www.dhs.state.il.us/page.aspx?item=83520.

The MA staff utilizes its Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The MA utilizes an exception report and review format as a component of the agency's financial accountability activity. MA staff have constructed database queries that encompass waiver eligibility, coding, and payment criteria. Based on these criteria, twice a year the MA conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. The identified exceptions are printed out with all relevant service data. Current exception reports identify paid claims for waiver services to customers who were in a nursing home or who are deceased. MA staff conduct targeted reviews based up on suspicion of fraud or inappropriate billing found in the exception report. Targeted reviews are not based upon a specific percentage or representative sample. The targeted reviews provide a detailed review of services and claims during the timeframe in question of individual waiver services, utilization of waiver services by individual customer, and billing trends and patterns of providers. These targeted reviews are paper based and are not conducted onsite. Targeted reviews do not vary among services. Claims and eligibility information are extracted from the data warehouse and reviewed in detail to determine anomalies is services, claims, billing trends and/or patterns. Death dates are verified to SSA/SSI death dates. Nursing home stays are compared to overlapping waiver services. If inappropriate billing is discovered, the OA is notified. The claim is adjusted or voided by the OA to reduce the state's claim for FFP. The OA will contact the provider to collect any overpayment. In cases of fraud, the HSP Medicaid Fraud Unit contacts the OA who will set up a receivable for any court-ordered restitution. The OA will also void or adjust any claims related to the restitution.

Continued to Main B Optional

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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, Person Centered Plans

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

Data Aggregation and Analysis:

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

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
I3: Number and percent of rates that are consistent with the approved rate methodology throughout the five-year waiver cycle. N: Number of rates that are consistent with the approved rate methodology throughout the five-year waiver cycle. D: Total number of rates.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Medical Data Warehouse, Encounter Data

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

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

Data Aggregation and Analysis:

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

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

The Medicaid agency (MA) will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs.

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

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

For the administrative claims review, the MA reviews the entire DHS claim to Medicaid administrative costs.

For the waiver claims review, MA staff utilize the Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The MA utilizes an exception report and review format as a component of the agency's financial accountability activity. MA staff have constructed database queries that encompass waiver eligibility, coding, and payment criteria. Based on these criteria, twice a year the MA conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. This review will include capitation payments made to MCOs and encounter claims submitted by MCOs.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an 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 States 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 30 days.

I2: The OA/MCO will determine whether the service was coded and paid correctly. If coded and/or paid incorrectly, the OA/MCO is notified, and the federal claim is voided and resubmitted. Remediation must be completed within 30 days.

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

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

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

The MA solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the waiver are proposed. The notice is published in accordance with Federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Whenever rates change, a listing of all covered services and corresponding rates are made available to customers and guardian (when applicable), family members, providers, stakeholders, and any interested parties.

The MA retains and exercises final authority over payment rates. It does so in collaboration with the OA which develops the proposed rates and shares the proposed rates and methodology with HFS for its approval. Rates of payment for program services since the initial 1915(c) waiver was approved have been established and updated as described below. The rates are available to the public through the OA's website:
http://www.dhs.state.il.us/page.aspx?item=83520.

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.

IL.0142.R07.00, effective 7/1/2021
Independent Provider (IP):
An agreement with the Service Employee International Union (SEIU) provides that hourly direct care staff rates receive periodic flat rate adjustments. To develop the rates, rate studies are performed, and Bureau of Labor Statistics information is analyzed to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. The rates were last reviewed in 2019, with approval of the current agreement, which was effective 7/1/2019 and ends 6/30/2023. In accordance with recent FLSA regulations, the State also allows for overtime and travel reimbursement to IPs. The rates do not include any direct or indirect administrative costs, are not geographically based, and exclude room and board costs. Rates and labor agreement are available to the public through the SEIU website and the Illinois Central Management Services website:
https://www2.illinois.gov/cms/personnel/employeeresources/Documents/emp_seiupast.pdf

IL.0142.R07.00, effective 7/1/2021
Home Health Extended State Plan and "Other" Services:
This includes RNs, LPNs, intermittent nurse visits, Home Health Aides (HHA), and therapies (OT, PT, and Speech). Rates for State Plan services are reviewed minimally every five years to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program.

Different rates are paid for RNs, LPNs, and HHAs depending on whether the service is provided by a licensed home health agency or by an independently licensed or certified provider. Historically, the independently licensed or certified provider rates were negotiated on an individual customer basis with rate ceilings based on the prevailing wage rates for these providers statewide. Beginning in July 2012, the SEIU contract was expanded to include independently licensed or certified providers using a fixed rate schedule for each type of service. These rates are available to the public through the SEIU website and the Illinois Central Management Services website in the published labor agreement. In accordance with FLSA regulations, the State also allows for overtime and travel reimbursement to home health service providers.

The rate for agency-based providers (RNs, LPNs, and intermittent nurse visits) were last reviewed in 2017 and set in 2018. The rates for agency-based providers are not geographically based and do not include room and board. The rate for agency based HHAs was last reviewed in 2018 and set in 2019. CNA rates are not geographically based and do not include room and board.

IP rates and increases in accordance with the agreement:
7/1/2021: IP $15.50, HHA $18.50, LPN $25.50, RN $32.25
1/1/2022: IP $16.00, HHA $19.00, LPN $26.00, RN $32.75
7/1/2022: IP $16.50, HHA $19.50, LPN $26.50, RN $33.25
12/1/2022: IP $17.25, HHA $20.25, LPN $27.25, RN $34.00

Agency based provider rates:
HHA $13.75, LPN $25.47, RN $29.55

Amendment IL.0142.R07.01, effective 2/1/2023
Increases the agency-based provider rates, effective 2/1/2023, or upon CMS approval:
RN $45.00, LPN $37.50, HHA $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://www2.illinois.gov/hfs/SiteCollectionDocuments/CopyofHomeHealthFeeScheduleeff11012019rev02042020Final.pdf

IL.0142.R07.00, effective 7/1/2021
OT, PT, and Speech Therapy:
State Plan services are reviewed minimally every five years to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. These rates were last reviewed in 2014. Therapy rates are not geographically based and do not include room and board. The State will perform a review of these rates by the end the calendar year 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. In the future, these rates will be reviewed minimally every five years.
OT, PT, Speech Therapy rate: $53.00

Amendment IL.0142.R07.01, effective 2/1/2023
Increases the OT, PT and Speech Therapy rates from $53.00 to $111.00, effective 2/1/2023, or upon CMS approval.
These rates are based upon the Home Health Fee Schedule effective 11/1/2019 and updated 2/4/2020.

https://www2.illinois.gov/hfs/SiteCollectionDocuments/CopyofHomeHealthFeeScheduleeff11012019rev02042020Final.pdf

The State completed a review of the OT, PT, and Speech Therapy rates on 12/6/2021.

IL.0142.R07.00, effective 7/1/2021
Homemaker:
The homemaker rate is a fixed unit rate based on the rates established by the IDoA in the Elderly Waiver (0143). Homemaker providers are required to expend a minimum of 73% of their total revenues on direct service worker costs. The remaining 27% of revenues may be spent by the provider agencies at their discretion on administrative or program support costs. See 89 IAC 240.2040. Expenses that may be counted as direct service worker costs include wages, health coverage, retirement, FICA, uniforms, workers compensation, travel reimbursement, FUTA, and unemployment insurance. Program support and administrative expenses include direct service worker supervisor costs, training costs, malpractice insurance, administration staff costs, consultant fees, supplies and equipment, telephone service, occupancy costs, and postage per 89 IAC 240.2050. The homemaker rate includes administrative costs and direct care staff wages. The rates are not geographically based and do not include room and board. Homemaker rates are reviewed by IDoA minimally every five years to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. The rate was last reviewed in 2020 and increased 6/1/2021.
Homemaker rate: $23.40
01/01/22 $24.96

Amendment IL.0142.R07.01, effective 2/1/2023
The homemaker rate will increase from $24.96 to $25.66 in this amendment (IL.0142.R07.01) effective January 1, 2023, in response to legislation passed by the Illinois General Assembly (GA) in Public Act 102-0017.

Revision to 2nd and 3rd sentences in the above rate methodology: Homemaker agencies are required to spend a minimum of 77% on direct service worker costs and the remaining 23% of their revenue may be spent by the provider agencies at their discretion on administrative or program support costs.

Amendment IL.0142.R07.05, effective 3/1/2023, or upon CMS approval.
The In-Home Service (homemaker) rate will increase from $25.66 to $26.92 in this amendment (IL.0142.R07.05) effective March 1, 2023, or upon CMS approval, in response to increased cost of living and previously established increases to minimum wage rates in Illinois.

IL.0142.R07.00, effective 7/1/2021
Adult Day Service (ADS):
ADS rates are based on rates established by the IDoA in the Elderly waiver (0143). ADS providers in this waiver are the same as used by the IDoA. They have the same staffing ratios and the same qualifications as the ADS providers used by the IDoA. The rate structure consists of two fixed unit rates, one for ADS and another for ADS transportation (ADST). ADS rates include both administrative and direct care costs. They are not geographically based and do not include room and board. ADS rates are reviewed minimally every five years by IDoA to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. The ADS and ADST rates were set in 2019 following a rate study completed in 2018. The study was conducted by an external vendor to ensure rates were efficient, cost effective, and allowed for the purchase of services at the lowest rate that will ensure access to waiver services by multiple providers. In the rate study, a thorough analysis of ADS and ADST programs was completed. This process included conducting focus groups which included participants, reviewing existing state data, and developing and distributing two provider surveys.
ADS rate: $14.30
01/01/22 $15.30

ADST rate: $10.29 per trip
01/01/22 $11.29 per trip

IL.0142.R07.00, effective 7/1/2021
Personal Emergency Response System (PERS):
PERS rates are based on the rates established by IDoA in the Elderly Waiver (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 years by IDoA to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. The PERS rates were set in 2019 following a rate study completed in 2018. The IDoA worked with an external vendor to perform a rate comparison of Medicaid PERS in other states. It was determined that Illinois' installation rate was below the Medicaid reimbursement levels established in other states.
PERS installation: $40.00
PERS monthly: $28.00

CONTINUED TO MAIN B OPTIONAL

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Provider Payment

The operating agency (OA) pays the provider directly. The three-party Medicaid waiver provider agreement is on file with the MA and allows the provider to voluntarily reassign payment to the OA. If a provider chooses to receive payment directly from the MA, the provider will sign the standard Medicaid provider agreement (HFS 1413). Providers may receive payment directly from the MA, if they choose not to voluntarily reassign payment to the OA.

The OA maintains a computerized payment system that includes PCP authorization for each customer, payments to provider agencies, units of service delivered to each eligible customer, and payment and claiming rates per unit of service.

The OA authorizes services in advance of service delivery. Both the provider and the customer report and certify that the service was delivered and the HSP Rehabilitation Counselor approves payment for the service. A combination authorization/voucher document is utilized in this payment process and constitutes a legal agreement between the OA and the provider.

The OA payment system contains edits to ensure that payments are made only when the customer is authorized for the program services delivered, via the PCP that specifies the program services, the provider of the program services, and the amount the services authorized.

OA claims processing
Payments are made by the State of Illinois Comptroller's Office from OA appropriation. The OA then submits the amount of expenditures for Medicaid eligible customers to the MA for submission of federal financial participation.

MA claims processing
The OA waiver claiming data is transmitted to the MA. The MMIS matches the customer against the recipient eligibility file to ensure Medicaid eligibility on the date of service and verifies the provider is enrolled as a waiver provider with the MA. MMIS includes edits for waiver claims that conflict with other waivers, hospitals, nursing home, hospice facilities, or institutional claims, and rejects waiver claims that are duplicative or incompatible. "The State currently operates a compliant EVV system for personal care services in this waiver. The State was approved for a Good Faith Effort exemption request for the implementation of an open/hybrid model Electronic Visit Verification (EVV) on November 21, 2019. On June 3, 2021, the MA posted a Request for Proposal (RFP) to secure the open/hybrid model Electronic Visit Verification (EVV). This system will be used for all personal care services. Customers have the choice to continue to use the current EVV system operated by the OA or change to the open/hybrid EVV model system that will be maintained by the MA."

The MA pays the MCOs a monthly capitated rate for waiver services.

This payment is generated from MMIS based on customer eligibility for waiver services. Waiver providers receive payment for services by billing the MCOs on a timely basis. The MCOs issue payments based on claims received and verification of individual customer waiver eligibility. These claims paid by the MCO are then submitted to the MA as encounter data.

Provider rates may be viewed at this link: http://www.dhs.state.il.us/page.aspx?item=83520

The State currently operates a compliant EVV system for personal care services in this waiver. The State was approved for a Good Faith Effort exemption request for the implementation of an open/hybrid model Electronic Visit Verification (EVV) on November 21, 2019. On June 3, 2021, the MA posted a Request for Proposal (RFP) to secure the open/hybrid model Electronic Visit Verification (EVV). This system will be used for all personal care services. Customers have the choice to continue to use the current EVV system operated by the OA or change to the open/hybrid EVV model system that will be maintained by the MA.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

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

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Provider billings are validated by the OA to verify the effective date of the customer's authorization for services according to the approved PCP. Customers also sign time sheets to verify that services were performed in accordance with the PCP. If inappropriate billing is discovered, the claim is adjusted or voided by the OA to reduce the state's claim for FFP. The OA will contact the provider to collect any overpayment. In cases of fraud, the HSP Medicaid Fraud Unit contacts the OA who will set up a receivable for any court-ordered restitution. The OA will also void or adjust any claims related to the restitution. When inappropriate billings are paid, the OA contacts the provider to collect the overpayment. The claim is voided and transmitted to the MA. The voided claim reduces the state's claim for FFP through an adjustment process. Paid claims are sent to the MA and MMIS processing edits are initiated for Medicaid and waiver eligibility. Lastly, the MA performs post-payment PCP and financial reviews.

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

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

The OA makes payments from a central computer system. Claims are edited and then sent to the MA for further editing and for Medicaid claiming. The audit trail is established through state agency approved rates, PCP authorizations, documentation of service delivery, and computerized payment, and claiming systems cross-matched with the MMIS.

Monthly capitated rates are paid by the MA to the MCOs. This payment is generated by the MMIS based on customer's eligibility for waiver services as identified in the database system. The MCOs receive a specific payment for customers eligible for waiver services.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The limited fiscal agent is a function of the OA.
The OA explains to providers that the waiver agreement voluntarily reassigns payment responsibility to the OA and that they have the option to bill the MA, directly, if they choose.
The provider signs the three-party Medicaid provider agreement that allows voluntary reassignment of pay. The OA makes payments directly to providers of waiver services and certifies those expenditures to the MA.

Illinois has developed a state operated payroll system for IPs. The customers must sign service calendars to verify the hours worked. The IP sends the hours worked to the OA for review and approval. The OA enters the payment into the WebCM, the OAs virtual case management system. WebCM includes internal edits to assure that the correct rates and the claims are within the service cost maximum. The OA operated payroll system pays IPs twice monthly. The payroll system withholds unemployment, FICA, union dues and other deductions as requested by the IP.

Services - The OA passes the detail expenditure data once a month to the MA. The MA is the Single Statewide Medicaid claiming agency for the State of Illinois. The data is fed into the Medicaid Management Information System (MMIS) and is subject to edits to ensure the information provided is accurate and that the services/providers are eligible for federal match under Title XIX. Should any claims have inaccurate information, those claims are rejected by the system and a file of the rejected claims is passed back to the OA for their review. Claims that pass through the system without error filter down to the MARS reporting unit. The MARS unit is responsible for generating the reports to the Bureau of Federal Finance (BFF) who use the reports to claim Medicaid expenditure data quarterly on the CMS 64. MARS also has a series of edits and codes that are used to filter data to ensure accuracy and to determine to what program the expenditure should be reported. The BFF report the expenditures on the CMS 64 on a quarterly basis 30 days after the quarter ends.

Federal Draws from the Medicaid Grant - In accordance with the Cash Management Improvement Act (CMIA), the BFF draws down federal monies from the Title XIX grant for the waiver on a weekly basis and deposits the funds into the General Revenue Fund (GRF). The amount to be drawn is an estimate derived by using historical expenditure data. Once the CMS 64 is completed at the end of the quarter, the BFF reconciles the estimated cash draw to the actual expenditures reported on the CMS 64. The reconciling expenditure amount is either added to or subtracted from the grant award depending on whether the adjustment is over or under the original estimated amount.

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

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 will have an enhanced rate is Homemaker (in-home service). This payment is only for in-home service provider agencies that provide health insurance. The source of the non-federal share of the enhanced payments would be the State of Illinois. Each service provider that receives the enhanced rate will retain 100% of the total computable expenditure claimed by the Medicaid Agency to CMS. With the public notice and the continuous posting of the rate increase on the HFS website, it is believed that the public is fully aware and that the intent is clear as to which providers are eligible for the enhanced payment.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ( ) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- (●) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

Department of Human Services-Division of Rehabilitation Services

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

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

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §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 §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 §1915(b)/§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 §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 ?1115/?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 ?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 textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §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 §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

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

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

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

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

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

The operating agency receives the non-federal share through the General Revenue Fund appropriations.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- (●) ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*
- ( ) ***Applicable***

Check each that applies:

- [ ] ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

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

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

Check each that applies:

- [ ] ***Health care-related taxes or fees***
- [ ] ***Provider-related donations***
- [ ] ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	22393.68	11826.78	34220.46	45669.65	12224.58	57894.23	23673.77
2	24055.66	12348.73	36404.39	47874.85	12757.36	60632.21	24227.82
3	24644.96	12894.12	37539.08	50187.03	13313.45	63500.48	25961.40
4	24564.71	13464.02	38028.73	52611.41	13893.89	66505.30	28476.57
5	24565.36	14059.55	38624.91	55153.44	14499.74	69653.18	31028.27

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	32401	32401
Year 2	33373	33373
Year 3	34373	34373
Year 4	35405	35405
Year 5	36468	36468

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) has been projected based on actual experience from the current waiver period, reflecting year-over-year increases during the new five-year waiver renewal period based on projected phase-in and phase-out assumptions. The calculation of the ALOS estimate of 307 for WY 1 in the renewal period is equal to the projected total number of days for participants on the waiver year during WY 1 divided by the unduplicated participant count 9,957,847/32,401.

The State reviewed enrollment trends in MMIS from January 2017 through September 2020 to estimate total enrollee growth of 5.5% annually through June 2021, and 3.0% annual growth beginning in July 2021. The difference in trend represents our best estimate of changes in enrollment due to the COVID-19 pandemic. We anticipate that the higher total enrollee growth will not be sustained long-term and will return closer to the average historical growth rate. For phase-out assumptions, we relied on historic trends to estimate that 1.7% of the monthly enrollee counts will phase-in each month. The phase-out assumption was derived by subtracting the total enrollee growth for each month from the phase-in counts derived from the 1.7% assumption.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Base year data reflects projections from experience incurred during the federal fiscal year 2019 period of October 1, 2018, through September 30, 2019 (FFY 2019). The sources of information for these future projections were provided by HFS and adjusted for some missing encounter claims and utilization not reported in the correct unit base.

The State adjusted a health plan's utilization to account for known deficiencies in the experience. The utilization was increased to align with average participation rates among the other health plans. Additionally, we adjusted the total units to account for known discrepancies among the health plans for the reporting of units for different services. For example, one health plan may have entered units as hours, but another may have entered units in 15-minute increments. These processes are consistent with the methodology utilized in the development of the capitation rates for the broader population.

IL.0142.R07.00, effective 7/1/2021
Factor D for the new 5-year waiver period for the renewal (July 1, 2021 through June 30, 2026) was projected from FFY 2019 in the following manner:

Unduplicated participants were adjusted based on total projected slots: The count of unduplicated participants per 1,000 total participants from FFY 2019 experience was utilized as the basis for projecting unduplicated users by category of service for all waiver years. As such, the growth in unique users for each service category between waiver years is a function of the growth in unduplicated participants. For example, the 25,959 projected users of independent providers in WY 2 of the renewal period is equal to 25,203 (# of users from WY 1) multiplied by the change in unduplicated participants from WY 1 to WY 2 (33,373/32,401).

The State reviewed enrollment trends in MMIS from January 2017 through September 2020 to estimate total enrollee growth of 5.5% annually through June 2021, and 3.0% annual growth beginning in July 2021. The difference in trend represents our best estimate of changes in enrollment due to the COVID-19 pandemic. We anticipate that the higher total enrollee growth will not be sustained long-term and will return closer to the average historical growth rate. For phase-out assumptions, we relied on historic trends to estimate that 1.7% of the monthly enrollee counts will phase-in each month. The phase-out assumption was derived by subtracting the total enrollee growth for each month from the phase-in counts derived from the 1.7% assumption.

IL.0142.R07.01, effective 2/1/2023
The assumption and methodology in unduplicated number of users are consistent with the waiver renewal (IL.0142.R07.00) except that we assumed a minimum of 10 users for each service in order to avoid the need for an amendment in the future should the number of users change by an amount that would have an immaterial impact to the total cost of waiver services.

Average units per user were projected to vary with average length of stay: The FFY 2019 experience in MMIS was utilized as the basis for projecting average units per user by category of service for WY 1. Amounts for WY 2 through WY 5 were calculated by multiplying the prior year average units per user by the change is ALOS between waiver years. As an example, the 1,606 projected units per user for independent providers in WY 3 renewal period is equal to 1,600 (# of units per user from WY 2) multiplied by the change in ALOS from WY 2 to WY 3 (308/307).

Average cost per unit was maintained across the length of the renewal period based on current fee schedules. See below for the expected rate increases for the renewal period:

Independent Providers:
01/01/21: $15
07/01/21: $15.50
01/01/22: $16
07/01/22: $16.50
12/01/22: $17.25

Respite Home Health Aide:
01/01/21: $18
07/01/21: $18.50

01/01/22: $19
07/01/22: $19.50
12/01/22: $20.25

Home Health Aide (Independent):
01/01/21: $18
07/01/21: $18.50
01/01/22: $19
07/01/22: $19.50
12/01/22: $20.25

Respite LPN:
01/01/21: $25
07/01/21: $25.50
01/01/22: $26
07/01/22: $26.50
12/01/22: $27.25

In-Home Shift Nursing-LPN (Independent):
01/01/21: $25
07/01/21: $25.50
01/01/22: $26
07/01/22: $26.50
12/01/22: $27.25

Respite RN:
01/01/21: $31.75
07/01/21: $32.25
01/01/22: $32.75
07/01/22: $33.25
12/01/22: $34.00

In-Home Shift Nursing RN (Independent):
01/01/21: $31.75
07/01/21: $32.25
01/01/22: $32.75
07/01/22: $33.25
12/01/22: $34.00

Homemaker:
01/01/22: $24.96

Adult Day Service
01/01/22: $15.30

Adult Day Service Transportation:
01/01/22: $11.29 per trip

Amendment IL.0142.R07.01, effective 2/1/2023
The average cost per unit was updated for Homemaker (effective 1/1/2023), Homemaker Respite (effective 1/1/2023), Home Health Aide CNA Agency (effective 2/1/2023), In-home Shift Nursing RN Agency (effective 2/1/2023), In-home Shift Nursing LPN Agency (effective 2/1/2023), and Intermittent Nursing (effective 2/1/2023) to align the rates for these services with Medicaid State Plan rates for similar services. WY 2 estimates were developed by weighting estimates with rate increases based on effective date using projected enrollment. For WY 3 through WY 5, we maintained the same cost per unit trend assumptions. Additionally, the average cost per unit was revised for Physical Therapy, Occupational Therapy, and Speech Therapy to reflect the appropriate rate ($111 per hour) which was originally effective October 2019 but was incorrectly reported in the waiver filing.

This change will align the rates for these services with Medicaid State Plan rates for similar services. Because the initial numbers were inaccurate, we adjusted the full WY 2 values to reflect the corrected cost per unit for those services.

Amendment IL.0142.R07.05, effective 3/1/2023, or upon CMS approval
The average cost per unit was updated for Homemaker and Homemaker Respite (effective 3/1/2023), or upon CMS approval, in response to increased cost of living and previously established increases to minimum wage rates in Illinois. WY 2 estimates were developed by weighting estimates with rate increases based on effective date using projected enrollment. For WY 3 through WY 5, we maintained the same cost per unit trend assumptions.

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:*

Base year data reflects projected benefit expenses illustrated in CY 2021 HealthChoice and MMAI capitation rates for services other than long term Care (LTC) for other rate cells. Factor D' was trended at a rate approximately 4.4% per year based on a blend of trend rates utilized in the 2021 capitation rates.

Since these members are available for enrollment in a managed care plan, we utilized the portion of the CY 2021 capitation rates related to acute services for the development of the G' and D' factors. For Factor D' we relied on capitation rates developed for members enrolled in a waiver, and for Factor G', we relied on capitation rates developed for members enrolled in a nursing facility. The underlying experience for nursing facility members shows significantly higher utilization associated with inpatient claims and transportation services than the experience for members enrolled in a waiver. These categories represent the significant reasons for the differences between factors G' and D'. The nursing facility members do experience lower utilization for outpatient claims, DME services, prescriptions, and office visits when compared to members enrolled on a waiver; however, these reductions do not fully offset the higher costs experienced in the inpatient claims and transportation services.

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:*

Base year data reflects projected benefit expenses illustrated in the CY 2021 HealthChoice and MMAI capitation rates for LTC services for Nursing Facility rates. Factor G was trended at a rate of approximately 4.8% per year based on a blend of trend rates utilized in the 2021 capitation rates.

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:*

Base year data reflects projected benefit expenses illustrated in the CY 2021 HealthChoice and MMAI capitation rates for non-LTC services for Nursing Facility rate cells. Factor G' was trended at a rate of approximately 4.4% per year based on a blend of trend rates utilized in the 2021 capitation rates.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Service	
Homemaker	
Individual Provider	
Respite	
Home Health Aide	
Occupational Therapy	

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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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:							***1215368.92***
Adult Day Service	☒	*Day*	*82*	*837.35*	*14.80*	***1016207.96***	
Adult Day Service Transportation	☒	*Day*	*72*	*256.36*	*10.79*	***199160.96***	
Homemaker Total:							***68049853.86***
HomeMaker	☒	*Hour*	*4534*	*588.58*	*25.50*	***68049853.86***	
Individual Provider Total:							***635250562.07***
Independent Provider	☒	*Hour*	*25203*	*1600.34*	*15.75*	***635250562.06***	
Respite Total:							***50552.45***
Respite RN	☒	*Hour*	*0*	*1.00*	*32.50*	***0.00***	
Respite LPN	☒	*Hour*	*2*	*283.00*	*25.75*	***14574.50***	
Respite Homemaker	☒	*Hour*	*6*	*235.15*	*25.50*	***35977.95***	

GRAND TOTAL:	***725577768.08***
Total: Services included in capitation:	*725577768.08*
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	***32401***
Factor D (Divide total by number of participants):	***22393.68***
Services included in capitation:	*22393.68*
Services not included in capitation:	
Average Length of Stay on the Waiver:	*307*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Independent Provider	☒	Hour	0	1.00	15.75	0.00	
Respite Home Health Aide (CNA)	☒	Hour	0	1.00	18.75	0.00	
Respite Adult Day Care	☒	Day	0	1.00	14.80	0.00	
Respite Adult Day Care Transportation	☒	Day	0	1.00	10.79	0.00	
Home Health Aide Total:							2139721.84
Home Health Aide Agency (CNA)	☒	Hour	33	444.09	13.75	201505.84	
Home Health Aide Independent (CNA)	☒	Hour	83	1245.44	18.75	1938216.00	
Occupational Therapy Total:							112865.62
Occupational Therapist	☒	Hour	82	25.97	53.00	112865.62	
Physical Therapy Total:							246982.12
Physical Therapist	☒	Hour	178	26.18	53.00	246982.12	
Speech Therapy Total:							44879.34
Speech Therapy	☒	Hour	22	38.49	53.00	44879.34	
Environmental Accessibility Adaptations Total:							2788275.70
Environmental Accessibility Adaptations	☒	Unit	289	1.28	7537.51	2788275.70	
Home Delivered Meals Total:							7770837.90
Home Delivered Meals	☒	Day/week	1778	291.37	15.00	7770837.90	
In-Home Shift Nursing Total:							5311131.38
In-Home Shift Nursing RN Agency	☒	Hour	217	132.76	29.55	851303.59	
In-Home Shift Nursing LPN Agency	☒	Hour	58	836.29	25.47	1235417.77	

GRAND TOTAL:	725577768.08
Total: Services included in capitation:	725577768.08
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	32401
Factor D (Divide total by number of participants):	22393.68
Services included in capitation:	22393.68
Services not included in capitation:	
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Shift Nursing Multi Customer Nurse	☒	Hour	0	1.00	47.28	0.00	
In-Home Shift Nursing RN Independent	☒	Hour	22	1745.52	32.50	1248046.80	
In-Home Shift Nursing LPN Independent	☒	Hour	31	2475.87	25.75	1976363.23	
Intermittent Nursing Total:							650841.34
Intermittent Nursing	☒	Hour	357	27.94	65.25	650841.34	
Personal Emergency Response System Total:							1620187.80
Personal Emergency Response (Monthly Monitoring)	☒	Month	6605	8.37	28.00	1547947.80	
Personal Emergency Response (Install)	☒	One Time	1720	1.05	40.00	72240.00	
Specialized Medical Equipment Total:							325707.74
Specialized Medical Equipment	☒	Unit	80	2.82	1443.74	325707.74	

GRAND TOTAL:	725577768.08
Total: Services included in capitation:	725577768.08
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	32401
Factor D (Divide total by number of participants):	22393.68
Services included in capitation:	22393.68
Services not included in capitation:	
Average Length of Stay on the Waiver:	307

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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:							**1290340.75**
Adult Day Service	☒	Day	84	837.35	15.30	**1076162.22**	
Adult Day Service Transportation	☒	Day	74	256.36	11.29	**214178.53**	
Homemaker Total:							**74378972.32**
HomeMaker	☒	Hour	4670	588.58	27.06	**74378972.32**	
Individual Provider Total:							**703742249.46**
Independent Provider	☒	Hour	25959	1600.34	16.94	**703742249.46**	
Respite Total:							**140843.39**
Respite RN	☒	Hour	10	1.00	33.69	**336.90**	
Respite LPN	☒	Hour	10	283.00	26.94	**76240.20**	
Respite Homemaker	☒	Hour	10	235.15	27.06	**63631.59**	
Respite Independent Provider	☒	Hour	10	1.00	16.94	**169.40**	
Respite Home Health Aide (CNA)	☒	Hour	10	1.00	19.94	**199.40**	
Respite Adult Day Care	☒	Day	10	1.00	15.30	**153.00**	
Respite Adult Day Care Transportation	☒	Day	10	1.00	11.29	**112.90**	
Home Health Aide Total:							**2388265.99**
Home Health Aide Agency (CNA)	☒	Hour	34	444.09	18.37	**277369.73**	
Home Health Aide Independent (CNA)	☒	Hour	85	1245.44	19.94	**2110896.26**	
Occupational Therapy Total:							**242144.28**
Occupational Therapist	☒	Hour	84	25.97	111.00	**242144.28**	
Physical Therapy Total:							**531794.34**
Physical	☒					**531794.34**	

GRAND TOTAL:	**802809579.46**
Total: Services included in capitation:	802809579.46
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**33373**
Factor D (Divide total by number of participants):	**24055.66**
Services included in capitation:	24055.66
Services not included in capitation:	
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapist		Hour	183	26.18	111.00		
Speech Therapy Total:							**98264.97**
Speech Therapy	☒	Hour	23	38.49	111.00	**98264.97**	
Environmental Accessibility Adaptations Total:							**2875107.81**
Environmental Accessibility Adaptations	☒	Unit	298	1.28	7537.51	**2875107.81**	
Home Delivered Meals Total:							**8002477.05**
Home Delivered Meals	☒	Day/week	1831	291.37	15.00	**8002477.05**	
In-Home Shift Nursing Total:							**6252340.22**
In-Home Shift Nursing RN Agency	☒	Hour	223	132.76	39.13	**1158462.43**	
In-Home Shift Nursing LPN Agency	☒	Hour	59	836.29	33.75	**1665262.46**	
In-Home Shift Nursing Multi Customer Nurse	☒	Hour	10	1.00	47.28	**472.80**	
In-Home Shift Nursing RN Independent	☒	Hour	22	1745.52	33.69	**1293744.51**	
In-Home Shift Nursing LPN Independent	☒	Hour	32	2475.87	26.94	**2134398.01**	
Intermittent Nursing Total:							**864195.38**
Intermittent Nursing	☒	Hour	368	27.94	84.05	**864195.38**	
Personal Emergency Response System Total:							**1668733.08**
Personal Emergency Response (Monthly Monitoring)	☒	Month	6803	8.37	28.00	**1594351.08**	
Personal Emergency Response (Install)	☒	One time	1771	1.05	40.00	**74382.00**	
Specialized							**333850.44**

GRAND TOTAL:	**802809579.46**
Total: Services included in capitation:	802809579.46
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**33373**
Factor D (Divide total by number of participants):	**24055.66**
Services included in capitation:	24055.66
Services not included in capitation:	
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Equipment Total:							
Specialized Medical Equipment	☒	Unit	82	2.82	1443.74	333850.44	

GRAND TOTAL:	802809579.46
Total: Services included in capitation:	802809579.46
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	33373
Factor D (Divide total by number of participants):	24055.66
Services included in capitation:	24055.66
Services not included in capitation:	
Average Length of Stay on the Waiver:	307

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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:							1338918.38
Adult Day Service	☒	Day	87	840.08	15.30	1118230.49	
Adult Day Service Transportation	☒	Day	76	257.20	11.29	220687.89	
Homemaker Total:							80238616.25
HomeMaker	☒	Hour	4810	590.50	28.25	80238616.25	
Individual Provider Total:							740500933.54
Independent Provider	☒	Hour	26737	1605.55	17.25	740500933.54	
Respite Total:							144996.50
Respite RN	☒	Hour	10	1.00	34.00	340.00	
Respite LPN	☒					77368.20	

GRAND TOTAL:	847121273.22
Total: Services included in capitation:	847121273.22
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	34373
Factor D (Divide total by number of participants):	24644.96
Services included in capitation:	24644.96
Services not included in capitation:	
Average Length of Stay on the Waiver:	308

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Hour	10	283.92	27.25		
Respite Homemaker	☒	Hour	10	235.92	28.25	66647.40	
Respite Independent Provider	☒	Hour	10	1.00	17.25	172.50	
Respite Home Health Aide (CNA)	☒	Hour	10	1.00	20.25	202.50	
Respite Adult Day Care	☒	Day	10	1.00	15.30	153.00	
Respite Adult Day Care Transportation	☒	Day	10	1.00	11.29	112.90	
Home Health Aide Total:							2616456.50
Home Health Aide Agency (CNA)	☒	Hour	35	445.54	25.00	389847.50	
Home Health Aide Independent (CNA)	☒	Hour	88	1249.50	20.25	2226609.00	
Occupational Therapy Total:							251564.85
Occupational Therapist	☒	Hour	87	26.05	111.00	251564.85	
Physical Therapy Total:							551118.33
Physical Therapist	☒	Hour	189	26.27	111.00	551118.33	
Speech Therapy Total:							98596.86
Speech Therapy	☒	Hour	23	38.62	111.00	98596.86	
Environmental Accessibility Adaptations Total:							2961939.93
Environmental Accessibility Adaptations	☒	Unit	307	1.28	7537.51	2961939.93	
Home Delivered Meals Total:							8269732.80
Home Delivered Meals	☒	Day/week	1886	292.32	15.00	8269732.80	
In-Home Shift Nursing Total:							6901344.95
In-Home Shift Nursing RN	☒	Hour	230	133.19	45.00	1378516.50	

GRAND TOTAL:	847121273.22
Total: Services included in capitation:	847121273.22
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	34373
Factor D (Divide total by number of participants):	24644.96
Services included in capitation:	24644.96
Services not included in capitation:	
Average Length of Stay on the Waiver:	308

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Agency							
In-Home Shift Nursing LPN Agency	☒	Hour	61	839.01	37.50	1919235.38	
In-Home Shift Nursing Multi Customer Nurse	☒	Hour	10	1.00	47.28	472.80	
In-Home Shift Nursing RN Independent	☒	Hour	23	1751.21	34.00	1369446.22	
In-Home Shift Nursing LPN Independent	☒	Hour	33	2483.93	27.25	2233674.05	
Intermittent Nursing Total:							1179194.07
Intermittent Nursing	☒	Hour	379	28.03	111.00	1179194.07	
Personal Emergency Response System Total:							1724654.40
Personal Emergency Response (Monthly Monitoring)	☒	Month	7007	8.40	28.00	1648046.40	
Personal Emergency Response (Install)	☒	One time	1824	1.05	40.00	76608.00	
Specialized Medical Equipment Total:							343205.87
Specialized Medical Equipment	☒	Unit	84	2.83	1443.74	343205.87	

GRAND TOTAL:	847121273.22
Total: Services included in capitation:	847121273.22
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	34373
Factor D (Divide total by number of participants):	24644.96
Services included in capitation:	24644.96
Services not included in capitation:	
Average Length of Stay on the Waiver:	308

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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:							**1381681.00**
Adult Day Service	☒	Day	90	837.35	15.30	**1153030.95**	
Adult Day Service Transportation	☒	Day	79	256.36	11.29	**228650.05**	
Homemaker Total:							**82372065.29**
HomeMaker	☒	Hour	4954	588.58	28.25	**82372065.29**	
Individual Provider Total:							**760237916.24**
Independent Provider	☒	Hour	27539	1600.34	17.25	**760237916.24**	
Respite Total:							**144528.27**
Respite RN	☒	Hour	10	1.00	34.00	**340.00**	
Respite LPN	☒	Hour	10	283.00	27.25	**77117.50**	
Respite Homemaker	☒	Hour	10	235.15	28.25	**66429.88**	
Respite Independent Provider	☒	Hour	10	1.00	17.25	**172.50**	
Respite Home Health Aide (CNA)	☒	Hour	10	1.00	20.25	**202.50**	
Respite Adult Day Care	☒	Day	10	1.00	15.30	**153.00**	
Respite Adult Day Care Transportation	☒	Day	10	1.00	11.29	**112.90**	
Home Health Aide Total:							**2669495.40**
Home Health Aide Agency (CNA)	☒	Hour	36	444.09	25.00	**399681.00**	
Home Health Aide Independent (CNA)	☒	Hour	90	1245.44	20.25	**2269814.40**	
Occupational Therapy Total:							**256557.63**
Occupational Therapist	☒	Hour	89	25.97	111.00	**256557.63**	
Physical Therapy Total:							**563760.12**
Physical	☒					**563760.12**	

GRAND TOTAL:	**869713647.09**
Total: Services included in capitation:	869713647.09
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**35405**
Factor D (Divide total by number of participants):	**24564.71**
Services included in capitation:	24564.71
Services not included in capitation:	
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapist		Hour	194	26.18	111.00		
Speech Therapy Total:							**102537.36**
Speech Therapy	☒	Hour	24	38.49	111.00	**102537.36**	
Environmental Accessibility Adaptations Total:							**3048772.04**
Environmental Accessibility Adaptations	☒	Unit	316	1.28	7537.51	**3048772.04**	
Home Delivered Meals Total:							**8491978.65**
Home Delivered Meals	☒	Day/week	1943	291.37	15.00	**8491978.65**	
In-Home Shift Nursing Total:							**7110331.20**
In-Home Shift Nursing RN Agency	☒	Hour	237	132.76	45.00	**1415885.40**	
In-Home Shift Nursing LPN Agency	☒	Hour	63	836.29	37.50	**1975735.12**	
In-Home Shift Nursing Multi Customer Nurse	☒	Hour	10	1.00	47.28	**472.80**	
In-Home Shift Nursing RN Independent	☒	Hour	24	1745.52	34.00	**1424344.32**	
In-Home Shift Nursing LPN Independent	☒	Hour	34	2475.87	27.25	**2293893.56**	
Intermittent Nursing Total:							**1209522.60**
Intermittent Nursing	☒	Hour	390	27.94	111.00	**1209522.60**	
Personal Emergency Response System Total:							**1770294.12**
Personal Emergency Response (Monthly Monitoring)	☒	Month	7217	8.37	28.00	**1691376.12**	
Personal Emergency Response (Install)	☒	One time	1879	1.05	40.00	**78918.00**	
Specialized							**354207.17**

GRAND TOTAL:	**869713647.09**
Total: Services included in capitation:	869713647.09
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**35405**
Factor D (Divide total by number of participants):	**24564.71**
Services included in capitation:	24564.71
Services not included in capitation:	
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Equipment Total:							
Specialized Medical Equipment	☒	Unit	87	2.82	1443.74	354207.17	

GRAND TOTAL:	869713647.09
Total: Services included in capitation:	869713647.09
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	35405
Factor D (Divide total by number of participants):	24564.71
Services included in capitation:	24564.71
Services not included in capitation:	
Average Length of Stay on the Waiver:	307

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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:							1413092.52
Adult Day Service	☒	Day	92	837.35	15.30	1178653.86	
Adult Day Service Transportation	☒	Day	81	256.36	11.29	234438.66	
Homemaker Total:							84849545.66
HomeMaker	☒	Hour	5103	588.58	28.25	84849545.66	
Individual Provider Total:							783067966.59
Independent Provider	☒	Hour	28366	1600.34	17.25	783067966.59	
Respite Total:							144528.27
Respite RN	☒	Hour	10	1.00	34.00	340.00	
Respite LPN	☒					77117.50	

GRAND TOTAL:	895849645.55
Total: Services included in capitation:	895849645.55
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	36468
Factor D (Divide total by number of participants):	24565.36
Services included in capitation:	24565.36
Services not included in capitation:	
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Hour	10	283.00	27.25		
Respite Homemaker	☒	Hour	10	235.15	28.25	66429.88	
Respite Independent Provider	☒	Hour	10	1.00	17.25	172.50	
Respite Home Health Aide (CNA)	☒	Hour	10	1.00	20.25	202.50	
Respite Adult Day Care	☒	Day	10	1.00	15.30	153.00	
Respite Adult Day Care Transportation	☒	Day	10	1.00	11.29	112.90	
Home Health Aide Total:							2756258.13
Home Health Aide Agency (CNA)	☒	Hour	37	444.09	25.00	410783.25	
Home Health Aide Independent (CNA)	☒	Hour	93	1245.44	20.25	2345474.88	
Occupational Therapy Total:							265205.64
Occupational Therapist	☒	Hour	92	25.97	111.00	265205.64	
Physical Therapy Total:							581196.00
Physical Therapist	☒	Hour	200	26.18	111.00	581196.00	
Speech Therapy Total:							106809.75
Speech Therapy	☒	Hour	25	38.49	111.00	106809.75	
Environmental Accessibility Adaptations Total:							3145252.17
Environmental Accessibility Adaptations	☒	Unit	326	1.28	7537.51	3145252.17	
Home Delivered Meals Total:							8745470.55
Home Delivered Meals	☒	Day/week	2001	291.37	15.00	8745470.55	
In-Home Shift Nursing Total:							7341687.49
In-Home Shift Nursing RN	☒	Hour	244	132.76	45.00	1457704.80	

GRAND TOTAL:	895849645.55
Total: Services included in capitation:	895849645.55
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	36468
Factor D (Divide total by number of participants):	24565.36
Services included in capitation:	24565.36
Services not included in capitation:	
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Agency							
In-Home Shift Nursing LPN Agency	☒	Hour	65	836.29	37.50	2038456.88	
In-Home Shift Nursing Multi Customer Nurse	☒	Hour	10	1.00	47.28	472.80	
In-Home Shift Nursing RN Independent	☒	Hour	25	1745.52	34.00	1483692.00	
In-Home Shift Nursing LPN Independent	☒	Hour	35	2475.87	27.25	2361361.01	
Intermittent Nursing Total:							1246738.68
Intermittent Nursing	☒	Hour	402	27.94	111.00	1246738.68	
Personal Emergency Response System Total:							1823544.24
Personal Emergency Response (Monthly Monitoring)	☒	Monthly	7434	8.37	28.00	1742232.24	
Personal Emergency Response (Install)	☒	One time	1936	1.05	40.00	81312.00	
Specialized Medical Equipment Total:							362349.87
Specialized Medical Equipment	☒	Unit	89	2.82	1443.74	362349.87	

GRAND TOTAL:	895849645.55
Total: Services included in capitation:	895849645.55
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	36468
Factor D (Divide total by number of participants):	24565.36
Services included in capitation:	24565.36
Services not included in capitation:	
Average Length of Stay on the Waiver:	307