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 who are Elderly

C. Waiver Number:IL.0143
Original Base Waiver Number: IL.0143.

D. Amendment Number:IL.0143.R07.03

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

03/01/23

Approved Effective Date: 03/01/23
Approved Effective Date of Waiver being Amended: 10/01/21

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 in-home service (homemaker) rate 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 in-home service (homemaker) rate increase effective March 1, 2023.

3. Update Appendix J-2-d to revise the in-home service (homemaker) rate to accommodate the rate increase effective March 1, 2023.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ Waiver Application	
☐ Appendix A Waiver Administration and Operation	
☒ Appendix B Participant Access and Eligibility	2-a
☐ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	2-a
☒ Appendix J Cost-Neutrality Demonstration	2-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 who are Elderly

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.0143
Waiver Number:IL.0143.R07.03
Draft ID: IL.020.07.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/21
Approved Effective Date of Waiver being Amended: 10/01/21

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:

Customers aged 60 or above.

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §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 in Cook County and surrounding border counties was approved for the effective date of May 1, 2011.

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

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

☐ **A program authorized under §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:

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

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

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

Customer need for CCP services is determined by local community agencies, Care Coordination Units (CCUs), which are under contract with the OA. Care Coordinators are employed by CCUs. Care Coordinators practice a person-centered approach to assessment, care planning and on-going care coordination. Customers are provided with the opportunity to lead the PCP process. Those that choose not to are still engaged at all levels of assessment and care planning. Care Coordinators evaluate applicants need for long term service and supports (LTSS) using a standardized needs assessment instrument, the Determination of Need (DON). This tool is part of a comprehensive care assessment and designed to identify all needs and risks of the customer, including health and well-being, social determinants of health, depression, suicide, substance abuse, and support to and from caregivers. In addition, all nursing facility applicants are evaluated prior to admission and, if eligible, are offered the option of community based LTSS. Customers in CCP are informed of their rights and responsibilities and their role in the PCP process. Rights and responsibilities are defined in brochures and validated at various points of the assessment and planning processes with signatures and other affirmations documenting participation and acknowledgement. The customer and provider(s) responsible for the implementation of the PCP receive a copy of the PCP.

Care Coordinators are trained to educate customers on available providers and assist in making informed choices. Customers are given choices and may receive one or more CCP services. Services available under the waiver include homemaker, adult day service, emergency home response service, and automated medication dispenser. Other services are available through the Older Americans Act (OAA) and the aging network and may be included in the PCP in addition to waiver services.

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

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

Illinois mandatory managed care program, now called HealthChoice Illinois, operates statewide, offering providers the opportunity to contract with MCOs in all Illinois counties. The HealthChoice program launched January 1, 2018. 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:

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

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

7. Contact Person(s)

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

Last Name: Winsel

First Name: Pamela

Title: Senior Public Service Administrator

Agency: Healthcare and Family Services

Address: 201 South Grand Avenue

Address 2:

City: Springfield

State: **Illinois**

Zip: 62763

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

Fax: (217) 557-2349

E-mail: Pamela.Winsel@illinois.gov

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

Last Name: Berkes

First Name: Mike

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

Agency: Illinois Department on Aging

Address: One Natural Resources Way, Suite 100

Address 2:

City: Springfield

State: **Illinois**

Zip: 62702-1271

Phone: (217) 558-3385 **Ext:** ☐ **TTY**

Fax: (217) 782-4477

E-mail: Mike.Berkes@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:

A Corrective Action Plan (CAP) will be implemented by the Medicaid Agency (MA) to address the Operating Agency's (OA) Training Tracking System for in-home service (homemakers) providers not being operational at the time of waiver renewal. The CAP requires the Training Tracking System to be operational by 5/1/2022. The OA will be able to report on homemaker training as of the waiver renewal date and be able to report data for the full five year waiver cycle. The OA will submit a bi-weekly progress report to the MA until the system is operational.

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 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):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Illinois Department on Aging

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

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. The MA contracts with a federally certified Quality Improvement Organization (QIO) to assist the MA in its role of an administrative oversight for the Persons who are Elderly Waiver. The QIO looks at the provider's staff training documents, the amount of training hours for each staff person, the current licensure's, and the results of the background checks. These documents are reviewed as part of onsite Comprehensive Provider Reviews; the QIO visits eight CCUs each year throughout Illinois, with 6 customers included in each site's sample. Sites and customers are designated by and randomly selected by the MA, respectively.

There are two broad types of program reviews: record reviews and onsite 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 reviewing components of customer eligibility, PCPs, provider qualifications, health and safety, care coordination, and how the system operates and communicates customer needs and issues.

The MA's ongoing quality monitoring includes sharing of reports from QIO reviews with the OA as well as directly with the review site. For sites with findings, a sample Corrective Action Plan template and guidance regarding expected remediation are included with the review findings. Review sites must submit a plan of correction to the OA for its review and any necessary follow up or clarification. The OA must provide a copy of its approval of the site's plan of correction to the MA. Other quality monitoring includes the MA's direct validation through random selection that review findings have been remediated.

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

For MCOs, the MA and the state's External Quality Review Organization (EQRO) provide quality oversight and monitoring of the Waiver Providers through record review audits of the customer PCP, reviewing the quality of services and supports provided to the HCBS program customers.

The state's EQRO performs Record Reviews to evaluate compliance with waiver performance measures as well as certain contractual components. The EQRO utilizes a tool that evaluates the following waiver assurances:

Level of Care— Customer records are examined to determine completeness and accuracy of Mini Mental State Exam (MMSE)/DON completed by the OA. The MCOs are required to obtain a copy of the score of the current DON obtained by the OA upon enrollment.

Qualified Providers—Responsibility for provider enrollment remains with the OA. The MCOs are responsible to ensure an evaluation of the worker's performance is completed annually, or according to the waiver requirements. Customer records are examined to determine the worker evaluation is completed.

Additional EQRO oversight of the MCOs includes review of initial MCO Care Coordinator qualifications and training, as well as ongoing annual training, and oversight of MCO Care Coordinator caseloads during the post implementation review and during the administrative compliance reviews.

PCP—Customer records are examined to determine that all assessed customer needs, goals, and risks are

addressed in the PCP; services are provided according to the PCP; PCPs are signed and dated by the customer and Care Coordinator; customers are contacted by the Care Coordinator per applicable waiver requirements; PCPs are updated when the customer's needs change; and that choice of services and providers was offered to the customer. PCPs are also reviewed for completeness, accuracy, and timeliness.

Health, Safety, and Welfare—Customer records are reviewed to determine that customers are aware of how and to whom to report abuse, neglect, and exploitation; and each customer has a backup plan.

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

Remediation—The EQRO will submit a report of findings to the MA at the conclusion of each onsite review. The report will consist of a summary of findings for each customer record reviewed, as well as a summary of overall findings detailed by Performance Measure and contractual requirements reviewed.

Remediation activities will be tracked by the EQRO to ensure 100% remediation of findings. Timeframes for completion of remediation will be reported in 30, 60, 90, or greater than 90 days. Remediation activities will be consistent with the approved activities detailed within each Performance Measure. HFS and EQRO will work collaboratively to follow up with the MCOs to ensure remediation occurs within the required time frames.

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

MCOs are required to submit quarterly reports, using the format required by the MA, on specific performance measures, which are described in MA's contracts with the MCOs. For each performance measure, contracts specify numerators, denominators, sampling approaches, data sources, etc. 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.

MA holds quarterly meetings with the OA to review program administration and evaluate system performance. Quarterly meetings also discuss broad topics, site reviews and remediation activities unless circumstances warrant communication prior to these meetings. The agencies also communicate regularly to follow up on issues raised during quarterly meetings. The MA also hold similar quarterly meetings with each of the MCOs independently to review program administration and adherence to waiver requirements.

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.:*

Care Coordination Units (CCU): OA Care Coordination services are performed by CCUs. CCUs perform the initial and ongoing waiver eligibility determinations for both the Fee For Service and MCO customers. For the MCO customers, the PCP development and ongoing monitoring is the responsibility of the MCO.

OA Care Coordination functions include:

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

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

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

4) Monitor service implementation.

5) Maintain customer records.

Illinois' mandatory managed care program, now called HealthChoice Illinois, began operating statewide effective January 1, 2018 offering providers the opportunity to contract with MCOs in all Illinois counties; additional MCOs will be available only to Cook County residents. The Integrated Care Program (ICP), Family Health Plan/ACA Adults (FHP/ACA) and Managed Long Term Services and Supports (MLTSS) MCO 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 an MCO, the MCOs will be responsible for care coordination, PCP development and oversight, customer safeguards, prior authorization of waiver services, and quality assurance and quality improvement activities.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

The Medicaid Agency (MA) conducts routine monitoring of a CCU's performance by selecting a sample of customer files.

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

The MA contracts with a Quality Improvement Organization (QIO) to conduct record reviews for the fee-for-service waiver customers. 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.

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 MCO reports and EQRO HCBS record reviews. The data source for some performance measures include questions related to customer satisfaction with services. Data is collected by either the OA or the MCO either by evaluating 100 percent of records or through a representative sample of records, based on the specific performance measure.

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

The MA contracts with a federally certified QIO to assist in its role of an administrative oversight for the OA. The QIO looks at the provider's staff training documents, the amount of training hours for each staff person, the current licensure's, and the results of the background checks. These documents are reviewed as part of onsite Comprehensive Provider Reviews. The QIO visits eight CCUs each year throughout Illinois, with 6 customers included in each site's sample. Sites and customers are designated by and randomly selected by the MA, respectively.

The MA's ongoing quality monitoring includes sharing of reports from QIO reviews with the OA as well as directly with the review site. For sites with findings, a sample Corrective Action Plan template and guidance regarding expected remediation are included as well. Review sites must submit a plan of correction to the OA for its review and any necessary follow up or clarification. The OA must provide a copy of its approval of the site's plan of correction to the MA. Other quality monitoring includes the MA's direct validation through random selection that review findings have been remediated.

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

The MA and OA hold quarterly meetings to discuss broad topics, site reviews and remediation activities unless circumstances warrant communication prior to these meetings. The agencies also communicate regularly to follow up on issues raised during quarterly meetings.

Appendix A: Waiver Administration and Operation

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

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

The Medicaid Agency (MA) and Operating Agency (OA) maintain separate but complementary processes to monitor customer welfare, service access, and quality. There is some duplication of review criteria for the MA and the OA reviews, but the same exact criteria are not utilized by both, and the reviews are not conducted concurrently.

The annual reviews referenced in this section by the MA are part of continued certification that the CCUs are complying with all administrative rules and policies for the Community Care Program that includes the waiver. The MA conducts Quality Improvement Reviews of CCUs on a three-year cycle. The MA has initiated conference calls with CCUs to discuss performance related goals and strategies for addressing performance issues.

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

The MA's monitoring activity is not intended to replicate the OA's reviews. The QIO performs two types of onsite reviews: Record Reviews and Comprehensive Provider Reviews. Record reviews are done through the state, based on a randomly drawn representative sample size. There are eight Comprehensive Provider Reviews at CCUs with a total of six customers reviewed at each site. In addition to the record review, the QIO also conducts two site visits to Community Service Providers and interviews with customers and staff from the CCU and community service provider agencies involved in their care and service provision.

Oversight of CCUs:

Quarterly:

The OA aggregates and analyzes CCU performance data in order to create management reports for completion of trend analysis and identification of insufficient performance by CCUs. The collected data assists the OA to identify potential performance problems for investigation and remediation. CCUs are required to use the feedback obtained by the OA and shared with CCUs as a central component of their own quality management strategy.

The OA reviews reports with CCUs in joint meetings and individually as needed. The OA conducts monitoring calls with CCUs who perform poorly for two or more quarters to discuss corrective action strategies and monitor CCU compliance with the corrective action plans. Monitoring calls continue until the CCU’s compliance improves and all corrective action activities have been completed.

Annually:

The OA conducts a desk audit of and conference call with each CCU. This audit includes a review of all performance reports, corrective action taken, and the policies and procedures maintained by the CCU.

Every three years:

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

The MA assesses the performance of the CCUs through comprehensive onsite reviews and statewide record reviews. The MA annually conducts comprehensive onsite provider reviews. A random sample of CCUs is drawn and then refined to ensure that CCUs with smaller caseloads are included. The MA makes sure that all regions are represented, and chooses two providers, usually one adult day service and one in-home service (homemaker) provider, serving customers whose care is coordinated by the CCU. Prior to the onsite reviews, the MA reviews the OA's records of critical events related to the CCU and providers; previous OA Quality Improvement (QI) and interim reviews conducted on the CCU and

providers, including follow-up and actions taken. The MA tracks previous findings to provide focus to the onsite review and to verify corrective action steps and ongoing compliance. During the CCU performance review, the MA completes at least six record reviews and customer interviews. Timeliness and content of assessments, PCPs and case notes are part of review of records. During customer interviews the MA validates that PCPs meet customer needs, are person centered including evidence that customers know how to contact the Care Coordinator. The MA also reviews policies, event reports, and personnel records for evidence of compliance with qualifications and training. Lastly, the MA interviews administrative staff about quality assurance measures; complaint receipt and handling; and the process for reporting abuse or neglect.

Reports are completed and sent to agencies (both CCU & providers) after the review, generally within 30 days. Agencies are prescribed a timeframe for completing corrective actions identified in the review. For issues of health, safety and welfare, the timeframe is generally 30 calendar days (or less depending on the severity); for most corrective actions the timeframe is 60 calendar days. If corrective action is not completed in its entirety, a second review is conducted with further corrective action. The OA may initiate contract action, up to and including termination, for an agency with extensive correction action expectations or issues that jeopardize health, safety, and welfare of customers.

Oversight of MCOs:

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

Once the MA selects the sample, it is provided to the OA and to the MA's External Quality Review Organization (EQRO), the entity responsible for monitoring the MCOs. The EQRO determines a review schedule, based on the MCO sample sizes and performs onsite reviews for those measures that require a record review. The EQRO then sends a report of findings to the MA and the MCOs. The MCOs are required to remediate findings within required timelines.

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

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

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐

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

Data Aggregation and Analysis:

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A4: Number and percent of active waiver participants compared to the approved waiver capacity. N: Total number of active waiver participants by waiver year. D: Total number of CMS approved waiver slots by waiver year.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A5: Number and percent of waiver customers receiving services in their home or community that state they are able to participate in meaningful activities that help meet their goals/needs. N: Number of waiver customers receiving services in their home or community that state they are able to participate meaningful activities that help meet their goals/needs. D: Total number of 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:
A6:Number and percent of waiver customers who state they feel supported in making decisions to remain independent to the greatest extent possible. N: Number of waiver customers who state they feel supported in making decisions to remain independent to the greatest extent possible. D: Total number of customers reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

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

The MA will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs.

The MA and OA entered into an interagency agreement that is reviewed and updated on at least an annual basis. The OA submits proposed policy changes to the MA for review and approval and the MA reviews and approves these changes.

The MA and OA meet on a quarterly basis to review program administration and to evaluate the system performance. The quarterly meeting provides opportunities to discuss trends, issues, and remediation activities.

The OA is responsible for following up on all overdue PCPs until remediation is complete. The MA works with the OA as needed to ensure required remediation has been completed.

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.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in the MA's contracts that provide waiver services. Contract details regarding MCO performance measures include numerators, denominators, sampling approaches, data sources, etc. MCOs submit the reports on a quarterly basis to a SharePoint site at the MA. MA staff review reports to ensure all required information is included in the report, as well as to identify any performance issues requiring follow up with a particular MCO.

Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver customers enrolled in an MCO through customer satisfaction data and quarterly record reviews.

The MA’s sampling methodology for the External Quality Review Organization (EQRO) quarterly record reviews has been finalized. The EQRO is the entity responsible for monitoring MCOs. The MA’s EQRO, will first determine the appropriate sample size for conducting sample by MCO and by Waiver, with proportional random samples based on an individual MCO’s waiver program distribution. Final sample size will be adjusted based on the actual MCO eligible population; MCO sample sizes will ensure a 95 percent confidence level and 5 percent margin of error. The MA will select samples by MCO and by OA fee-for-service population.

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 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 OA or MCO Care Coordinator will inform the provider of interview responses. The OA or MCO will continue to follow-up with customer to determine satisfaction. If no change, Care Coordinator will follow-up with the provider until resolution. Initial follow-up will occur within 30 days of the finding.

A6: The OA or MCO Care Coordinator will inform the provider of interview responses. The OA or MCO will continue to follow-up with customer to determine satisfaction. If no change, Care Coordinator will follow-up with the provider until resolution. Initial follow-up will occur within 30 days of the finding.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

1. Be a U. S. citizen or legal alien
2. Be a resident of the State of Illinois.
3. Be over age 60 at the time of application.
4. Be Medicaid eligible.
5. Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment. Must meet the DON threshold of 29 to be eligible for the waiver and/or nursing home placement and a maximum of 100 DON score.
6. Estimated cost to the State for home care is less than estimated cost for institutional care.
7. Can be safely maintained in the home or community-based setting with the services provided in the plan of care.

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

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

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

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

The state may periodically update SCMs based on factors such as changes in provider rates or other factors that impact the cost of waiver services.

All waiver services except the installation of the Automated Medical Dispenser (AMD) and the Emergency Home Response System (EHRS) are included in the Service Cost Maximum. However, the monthly rates are included.

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

◉ **Other:**

Specify:

IL.0143.R07.00
The installation of the AMD and the EHRS are not included in the Service Cost Maximum, however, the monthly rates are included.

The new methodology establishes Service Cost Maximums based on individual Determination of Need scores instead of a range of scores. The result is that each individual Determination of Need score has a specific Service Cost Maximum rather than a range of Determination of Need scores linking up to one Service Cost Maximum.

Monthly Service Cost Maximum (SCM)
DON = DON Score
HM SCM = Homemaker
ADS SCM = Adult Day Service

Amendment IL.0143.R07.01 amended the Service Cost Maximums in the following manner.

SCMs Effective 1/1/2023

DON	HM SCM	ADS SCM
29	$645	$1,321
30	$721	$1,535
31	$799	$1,766
32	$876	$1,992
33	$952	$2,222
34	$1,031	$2,449
35	$1,108	$2,589
36	$1,183	$2,727
37	$1,261	$2,865
38	$1,338	$3,002
39	$1,414	$3,141
40	$1,492	$3,281
41	$1,569	$3,419
42	$1,644	$3,558
43	$1,724	$3,696
44	$1,800	$3,834
45	$1,879	$3,974
46	$1,953	$4,113
47	$2,031	$4,251
48	$2,109	$4,388
49	$2,183	$4,527
50	$2,262	$4,666
51	$2,339	$4,805
52	$2,416	$4,944
53	$2,492	$5,080
54	$2,566	$5,219
55	$2,646	$5,359
56	$2,723	$5,494
57	$2,802	$5,635
58	$2,876	$5,773
59	$2,955	$5,912
60	$3,032	$6,050
61	$3,107	$6,188
62	$3,185	$6,327
63	$3,264	$6,464
64	$3,339	$6,605
65	$3,416	$6,741
66	$3,495	$6,881
67	$3,569	$7,022

68	$3,647	$7,157
69	$3,724	$7,298
70	$3,800	$7,436
71	$3,878	$7,574
72	$3,955	$7,713
73	$4,030	$7,852
74	$4,110	$7,989
75	$4,186	$8,127
76	$4,264	$8,267
77	$4,340	$8,405
78	$4,417	$8,545
79	$4,495	$8,682
80	$4,569	$8,819
81	$4,648	$8,959
82	$4,725	$9,098
83	$4,802	$9,235
84	$4,879	$9,374
85	$4,958	$9,514
86	$5,033	$9,650
87	$5,109	$9,790
88	$5,188	$9,927
89	$5,262	$10,064
90	$5,341	$10,205
91	$5,418	$10,342
92	$5,493	$10,482
93	$5,571	$10,622
94	$5,650	$10,757
95	$5,725	$10,898
96	$5,802	$11,037
97	$5,881	$11,175
98	$5,955	$11,313
99	$6,033	$11,451
100	$6,111	$11,590

Amendment IL.0143.R07.03 updates the Service Cost Maximums in the following manner effective 3/1/2023, or upon CMS approval.

SCMs Effective 3/1/2023

DON	HM SCM	ADS SCM
29	$686	$1,395
30	$766	$1,620
31	$848	$1,862
32	$929	$2,099
33	$1,008	$2,341
34	$1,091	$2,579
35	$1,172	$2,726
36	$1,251	$2,870
37	$1,332	$3,015
38	$1,413	$3,159
39	$1,493	$3,305
40	$1,575	$3,452
41	$1,656	$3,596
42	$1,734	$3,742
43	$1,818	$3,887
44	$1,898	$4,032
45	$1,981	$4,179
46	$2,058	$4,324

47	$2,140	$4,469
48	$2,222	$4,613
49	$2,300	$4,759
50	$2,383	$4,905
51	$2,463	$5,050
52	$2,544	$5,196
53	$2,624	$5,339
54	$2,701	$5,485
55	$2,785	$5,632
56	$2,866	$5,773
57	$2,949	$5,921
58	$3,027	$6,066
59	$3,110	$6,212
60	$3,190	$6,357
61	$3,269	$6,501
62	$3,351	$6,647
63	$3,434	$6,791
64	$3,512	$6,939
65	$3,593	$7,082
66	$3,676	$7,228
67	$3,754	$7,376
68	$3,836	$7,518
69	$3,916	$7,666
70	$3,996	$7,811
71	$4,078	$7,955
72	$4,159	$8,101
73	$4,237	$8,247
74	$4,321	$8,391
75	$4,401	$8,536
76	$4,483	$8,682
77	$4,563	$8,827
78	$4,643	$8,974
79	$4,725	$9,118
80	$4,803	$9,262
81	$4,886	$9,408
82	$4,967	$9,554
83	$5,047	$9,698
84	$5,128	$9,844
85	$5,211	$9,991
86	$5,290	$10,133
87	$5,369	$10,280
88	$5,452	$10,424
89	$5,530	$10,568
90	$5,613	$10,716
91	$5,694	$10,859
92	$5,772	$11,006
93	$5,854	$11,153
94	$5,937	$11,295
95	$6,016	$11,443
96	$6,096	$11,588
97	$6,179	$11,733
98	$6,257	$11,878
99	$6,339	$12,023
100	$6,421	$12,169

Appendix B: Participant Access and Eligibility

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

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

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

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

The Person-Centered Plan (PCP) that is developed in collaboration with the customer is based upon the assessment. The PCP identifies all services and supports - both formal and informal, the need for additional evaluation(s), customer expressed goals, needs and wants, and service arrangements. It also includes identification of service needs being met by existing support systems including public, private, family and community and those funded by programs other than the Illinois HCBW services provided through the Community Care Program (CCP) Care Coordinators are trained to utilize other local, state, and federal funded services when available to assist in meeting customers' needs and fill-in gaps where traditional CCP services are not available or adequate.

If a customer does not meet eligibility requirements, the Operating Agency (OA) sends the customer a Client Action 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 Client Action Notice and request a hearing. The notice explains how to request an appeal with the appropriate forms enclosed. All services 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:

Interims and Temporary Service Increase (TSIs) refers to assessment types that are completed when a current customer is at imminent risk of entering a nursing facility.

Interims are completed for new referrals for customers needing waiver services and TSIs are completed on existing customers who need additional services to remain independent in the community. OA Care Coordinators complete a new DON and use the appropriate Service Cost Maximum to authorize a level of services based on the current needs of the customer.

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	124498
Year 2	132591
Year 3	141209
Year 4	150389
Year 5	160164

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

:

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ○ **§1634 State**
- ○ **SSI Criteria State**
- ◉ **209(b) State**

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

- ◉ **No**
- ○ **Yes**

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

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

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☐ **SSI recipients**
- ☒ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional state supplement recipients**
- ☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☒ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 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 waiver 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:

The CCU is responsible for performing evaluations and reevaluations.

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

Minimum qualifications for Care Coordinators:

1)Be an R.N, or have a B.S.N, or have a B.A./B.S. degree in social science, social work or related field. One year of program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education up to and including four years of experience replacing a baccalaureate degree; or,
2)Be an LPN with one year of program experience which is defined as assessment of a provision of formal services for the elderly and /or authorizing service provision; or
3)Be waived for persons hired/serving in this capacity prior to December 31, 1991 Provision of a waiver for care coordinators hired prior to December 31, 1991 was based on their years of experience. These care coordinators must maintain certification for a case manager and must also follow in-service requirements.

OA Care Coordinators must also complete the following IDoA sponsored training:
1)Preliminary Care Coordination certification training which must occur prior to conducting customer assessments;
2) Care Coordination Certification training and successfully pass the required exam within six months of completing Preliminary training; and
3)Recertification training within each 18-month anniversary of each previous certification.

Care Coordinators must also complete 18 hours of documented in-service training on aging -related subjects within each calendar year. For partial years of employment, training is prorated for each full month of employment.

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

The entry point into the waiver, or initial Level Of Care 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 nursing facility. The extent and degree of a customer's need for long term care is determined based on consideration of pertinent medical, social and psychological factors as measured by application of the DON.

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

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

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

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

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

The CCUs conduct the Level Of Care evaluations and reevaluations utilizing the DON as described above.

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

Additionally, the DON includes the standardized Mini-mental State Exam (MMSE). The final score is calculated by adding the results of the MMSE, the level of impairment, and the unmet need. The minimum threshold for eligibility is a score of 29.

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

For customers enrolled in an MCO, the re-evaluations are conducted by the OA.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

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

  Specify the qualifications:

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

OA Care Coordinators enter customer demographic and assessment information into the relational computerized database, Case Management Information System (CMIS). The CMIS offers one method used by the CCUs to ensure the timely reevaluation of customers.

The CMIS generates standard reports, which also assist the CCUs as a way to track customers and caseloads. Care coordination reports are provided OA Care Coordinators with a reminder of customer assessments due in given month. The OA Care Coordinator supervisors use standard reports to monitor and evaluate OA Care Coordinator activities, and include current month assessment status, upcoming assessments and case management projections.

Customer assessment information is transmitted via CMIS to the OA's Internet-based billing system, electronic CCP Information System (eCCPIS). CCU's periodically review the eCCPIS, to run the redetermination due report or the overdue report to prevent untimely annual redeterminations.

The eCCPIS reports are available to the CCUs to track when annual eligibility determinations are due. The OA encourages the CCUs to review the eCCPIS frequently. OA quality assurance monitoring staff review eCCPIS redetermination due reports at least twice a year with the CCUs.

The OA and MA monitor timeliness of reevaluations during monitoring activities.

The OA is developing a new comprehensive care coordination data system, Aging Cares, which will combine all independent systems into one web-based care coordination system housed at the State level. The new Aging Cares system will contain all the information from the CMIS system. This new system will completely replace all paper files for the CCUs and the service providers. This will allow the OA to have access to all the data in the customer's files, not only from the CCU, but also from waiver service providers.

Aging Cares will operate in real time and information will immediately be available to providers, CCUs and OA monitoring staff. This new system will allow the State to more accurately report on all waiver performance measures and will also allow compliance auditing on 100% of customers through data mining in addition to on-site record validation auditing.

Aging Cares development has occurred in phases. Programming of all CCP forms is complete. Testing has begun and anticipated to be completed in September 2021. Training for CCUs and provider agencies will between September 2021 through December 2021.

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

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

The State requires that CCUs adhere to the OA's standards and policies which requires that all written and/or electronic documentation related to all evaluations, reevaluations and customer care are maintained for a minimum period of 6 years after the contract terminates under which the customer was served. Active customers' records can never be purged regardless of contract termination dates. CCUs are required to maintain records in a secure, confidential location that is readily accessible during this period.

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the 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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Care Coordination Units (CCUs) conduct Level of Care (LOC) determinations. The state has a two-pronged approach to ensuring that LOC determinations are done in an accurate and timely fashion.

First, the OA requires each CCU to maintain written and up-to-date policies for ensuring that all customers potentially eligible for the waiver are given the opportunity to apply. CCUs must submit these policies to the OA on an annual basis. The OA reviews these policies using a checklist tool and aggregates the results in an Access database. The OA also conducts reviews once every three years to ensure that the CCUs are following their written policies.

Second, the state maintains tracking databases in which the CCUs enter information about customer LOC determinations. These databases contain individual customer level and item level information from the LOC determination tools. Information is collected on a continuous basis. The OA extracts information from these databases regarding the timeliness of the eligibility determinations and redeterminations. The information is summarized in quarterly management reports. The databases also contain edits that ensure that only customers who meet the LOC eligibility threshold are determined eligible for the program.

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

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

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

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. Customer 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 from the CCU to include a reassessment or justification if in error. If the justification is inadequate and/or the reassessment does not result in the required scoring, the waiver eligibility will be discontinued and the OA will assist the customer with accessing other supports and services. Federal claims will be adjusted and the OA will provide technical assistance or training to Care Coordinators. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

For customers enrolled in an MCO, preference for institutional or home and community-based services is documented on a Freedom of Choice form provided by the MCO and approved by the MA. The customer must sign the completed form indicating his/her choice and that he/she has made an informed decision.

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

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

The State requires that CCUs adhere to the OA's standards and policies which requires that all written and/or electronic documentation and forms related to all evaluations, reevaluations and customer care are maintained for a minimum period of 6 years after the contract terminates under which the customer was served. Active customers records can never be purged regardless of contract termination dates. CCUs are required to maintain records in a secure, confidential location that is readily accessible during this period. Records are kept securely at the local CCUs or at a secure storage facility until they can be purged by the CCU. Electronic data submitted to the OA is stored indefinitely in the OA's data system and is backed up on secure data servers at the State of Illinois's Department of Information Technology.

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

Appendix B: Participant Access and Eligibility

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

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

The State provides access to waiver services to all eligible seniors in Illinois including Limited English Proficient persons. The State has translated the six brochures that Care Coordinators are required to provide and explain to participants/authorized representatives when completing the comprehensive assessment. The languages include Spanish, Hindi, Russian, Polish, and Chinese using both simplified and traditional characters. The required brochures include: Participant Bill of Rights, Notice of Privacy Practices, Requesting Services and Supports, Your Rights and Responsibilities, Your Right to Appeal, and Your Need to Know (CCP-ANE). Many Care Coordination Units have bilingual Care Coordinators to perform assessments on non-English speaking customers.

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Service**		
Statutory Service	**In-Home Service (Homemaker)**		
Other Service	**Automated Medication Dispenser (AMD)**		
Other Service	**Emergency Home Response Service**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

Reassessing the customer's needs and reevaluating the appropriateness of the PCP shall be done as needed, but at least semi-annually.

A balance of purposeful activities to meet the customer's interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical, and spiritual) designed to improve or maintain the optimal functioning of the customer.

Activity programming shall take into consideration individual differences in age, health status, sensory deficits, lifestyle, ethnicity, religious affiliation, values, experiences, needs, interests and abilities by providing for a variety of types and levels of involvement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Service

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Adult Day Service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

89 Ill. Admin. Code 240

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

In-Home Service (Homemaker)

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) provided by a trained homecare aide, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homecare aides shall meet such standards of education and training as are established by the State for the provision of these activities.

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

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

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

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

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

Observing customers' functioning and reporting to the supervisor.

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

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

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

Service is limited by the service cost maximum. There is a process for the provision of temporary service increases. When a customer is at imminent risk of entering a nursing facility, Care Coordinators complete a new DON and use the appropriate service cost maximum to authorize a level of services based on the current needs of the customer. Under this TSI process, new or increased level of services are expedited so that they are implemented within two days.

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homemaker Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In-Home Service (Homemaker)

Provider Category:

Agency

Provider Type:

Homemaker Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

89 Ill Admin Code 240
Homecare aides are required to have a high school or general education diploma, or one year employment in a comparable human services field, or demonstration of continued progress towards meeting the requirements of a general education diploma. Newly-hired home care aides must receive 24 hours of initial pre-service training and are subject to a competency evaluation conducted by the agency. Thereafter, a minimum of 12 hours of annual training is required.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Automated Medication Dispenser (AMD)

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:**

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

Waiver customers are afforded freedom of choice of providers regardless of whether the same AMD provider also provides EHRS services. The OA participant agreement form contains a consent form which documents freedom of choice of provider.

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

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

This service does not include OA or AMD provider medication management, oversight or handling of the customer’s medications. The customer or assisting party must be responsible for managing the acquisition of all prescribed medications, including assuring the medications are administered according to physician orders, and must manually fill the AMD. The customer or responsible party is to work with the AMD provider to program the dispenser initially and to reprogram the dispenser with any changes in the medication schedule.

In addition, the customer must have a willing family member/assisting party to act on AMD provider notification of missed medication doses and other system issues such as power outages.

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

The state offers this service through the Request for Certification to assure that any willing and qualified providers have the opportunity to provide this service. Administrative Rules have been written to identify required automated medication dispenser service components, minimum equipment specifications and administrative requirements.

The one-time installation is separate from the monthly rental and service cost. The installation rate covers the following: maintaining adequate local staffing levels of qualified personnel to service necessary administrative activities, installation, and in-home training. The monthly rental and service rate covers the following: maintaining administrative and technical support to program machines, provide 24-hour technical assistance, signal monitoring, troubleshooting, providing machine maintenance and repair requests, sending notifications on missed medication doses and providing reports.

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

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

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

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

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Automated Medication Dispenser Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Automated Medication Dispenser (AMD)

Provider Category:

Agency

Provider Type:

Automated Medication Dispenser Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

As specified in the OA Community Care Program Standards for Automated Medication Dispenser Services. This document is posted on the OA website at the following link - http://www.ilga.gov/commission/jcar/admincode/089/08900240sections.html

Provider standards are in administrative rule. Providers must meet the standards as specified in Title 89 Section 240 or the Illinois Administrative Code. The web address for the AMD application is available at: https://www2.illinois.gov/aging/forprofessionals/Procurement/Pages/certificationpacket.aspx

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

AMD providers are reviewed on the same schedule as EHRS providers - verification occurs 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:

Emergency Home Response 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:**

Emergency home response service (EHRS) is defined as a 24-hour emergency communication link to assistance outside the customer's home for the customer's health and safety needs and due to mobility limitations. This service is provided by a two-way voice communication system consisting of a base unit and an activation device worn by the customer that will automatically link the customer to a professionally staffed support center. The support center assesses the situation and directs an appropriate response whenever this system is engaged by a customer. The purpose of providing EHRS is to improve the independence and safety of customers in their own homes in accordance with the authorized PCP, and thereby help reduce the need for nursing home care.

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

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

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

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

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

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Home Response Service

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Emergency Home Response Service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

As specified in the OA's Community Care Program Standards for Emergency Home Response Services. This document can be found at:
http://www.ilga.gov/commission/jcar/admincode/089/08900240sections.html

Provider standards are in administrative rule. Providers must meet the standards as specified in Title 89 Section 240 of the Illinois Admin. Code.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of enrollment and annually.

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:

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

For customers enrolled in an MCO, care coordination is provided by the MCO.

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 OA conducts a compliance review for each CCU once every three year contract period to ensure compliance with contractual obligations. After conducting compliance reviews, the OA summarizes information on each performance indicator targeting the following users: the MA, the OA, CCUs, providers and Care Coordinators. The MA and OA review the statewide performance data during quarterly meetings. The summarized data assists the two agencies with identifying potentially problematic trends and tracks the effects of remediation efforts to improve performance. Similarly, detailed reports for each level of entity are shared quarterly. These reports provide the basis for trend identification and specific areas of problems, leading to remediation. When individual problems with existing provider qualifications and contract compliance are identified, there is an initial effort to resolve the situation. In the case of problems identified through the complaint system, the State requires resolution within fourteen days. For other types of compliance problems, the State makes an initial request for corrective action. This corrective action request is tracked until there is a successful resolution. If there is not successful resolution, the State may take contract action under Rule 240.1665. These actions include 1) suspension of new referrals; 2) fines; or 3) contract cancellation.

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

The MA and OA meet quarterly to discuss summary reports that include statewide data and corrective action that has been taken by the OA. This provides an opportunity for both agencies to identify trends and issues, and to discuss remediation steps.

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

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

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

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. Providers must meet all qualifications and pass all screening checks to be approved and entered in IMPACT (HFS Inspector General’s Office, the Illinois Department of Public Health’s Health Care Worker Registry, a Healthcare Worker Background Check, the Illinois Department of Professional and Financial Regulation registry, etc.).

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 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.

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):

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.*

Each homecare provider agency has established an agency-specific policy regarding the hiring and assignment of homecare workers to customers who are family members. The policy must include the State policy and procedures for Family Members as Homecare Workers and must specify the circumstances under which the homecare worker shall be allowed to service family members as well as circumstances which would preclude such an assignment. Circumstances that may allow a family member to provide direct care services can include language barriers or worker availability.

The State will pay relatives to provide in-home (homemaker) services under specific conditions. This condition is the relative cannot be a legally responsible person to the customer, i.e. spouse, guardian, person(s) with Power of Attorney or representative payee.

Care Coordinators refer interested family members to the customer’s chosen homecare provider. The family member must apply to the provider agency for employment as family caregiver. When developing the PCP, Care Coordinators will only schedule evening/weekend services based on customer's needs, not to accommodate family member availability. Family members hired as homecare workers cannot be a customer's authorized representative and may not sign the Client Agreement, Vendor Selection or Eligibility form, or PCP. The PCP is signed by homemaker agency which employs all eligible relatives providing waiver services and ensures the worker is informed regarding the requirements of the PCP.

Homecare providers must provide documentation substantiating the reason for hiring the family member. Providers must report the assignment of the family member and his or her relationship to the customer to the CCU; both the provider and the CCU keep documentation of the notification. Providers conduct more intensive monitoring/supervision of family members including at a minimum monthly phone monitoring during hours of service to ensure the homecare worker is there and accurately reporting hours worked and quarterly unannounced visits to ensure the homecare worker is following the PCP.

A family member cannot be hired as a home care aide if the family member is a legally responsible person to the customer (spouse, guardian, person(s) with Power of Attorney and representative payees). Therefore, the OA does not allow legal guardians to provide Community Care Program services to a customer. Other non-legally responsible persons, including relatives, can be hired as a home care aide to provide services to a customer. All home care aides are hired through an agency and are required to complete all service tasks outlined on the customer's PCP.

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

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

○ **Other policy.**

Specify:

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

The OA is compliant with the federal "all willing and qualified provider" provisions.

The application and the description of the process to become a Community Care Program/Waiver certified provider is outlined on the OA website: https://www2.illinois.gov/aging/forprofessionals/Procurement/Pages/default.aspx. All applications are reviewed by the OA fiscal/contract staff. There are no restrictions on the application process – The OA reviews all applications to determine compliance with the Waiver and CCP Administrative Rule requirements found at 89 Illinois Administrative Code 240.1600. This link can be found at the OA website located at: https://www2.illinois.gov/aging/aboutus/pages/rules-main.aspx

MCO:

MCO Care Coordinators are also required to enable as much choice as possible with the MCOs offering options of providers in order to accommodate customer preferences and choice. MCOs must offer contracts to all willing and qualified providers in the contracting area that offer HCBS waiver services, as long as the provider adheres to the MCO's quality requirements (Section 5.7.1.2 of MCO contract). By terms of their contract with the MA, 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 eighty percent (80%) of the number of customers in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) of such Providers, so long as such Providers accept Contractor's rates, even if one (1) served more than eighty percent (80%) of the customers, unless the MA grants Contractor an exception. All MCOs provide statewide coverage, with the exception of CountyCare, which covers Cook county, only. County Care must offer contracts to all providers in Cook county.

Additionally, 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 (Section 5.7.1.2 of MCO contract). To be considered a qualified provider, the provider must be in good standing with the MA's Fee for Service (FFS) Medical Program. MCOs may establish quality standards in addition to those State and Federal requirements and contract only with providers that meet such standards. Such standards must be approved by the MA, in writing, and MCOs may only terminate the contract of a provider based on failure to meet such standards if two criteria are met a) such standards have been in effect for at minimum one (1) year, and b) providers are informed at the time such standards come into effect.

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

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

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

Performance Measure:
C4: Number and percent of in-home workers (homemakers) who received training in accordance with state requirements and the approved waiver. N: Number of in-home workers (homemakers) who received training in accordance with state requirements and the approved waiver. D: Total number of in-home workers (homemakers).

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

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

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Certification Reports/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:
C6: Number and percent of OA and MCO Care Coordinators who receive training in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. N: # of OA and MCO Care Coordinators who receive training in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. D: Total # of OA and MCO Care Coordinators.

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 OA conducts a compliance review for each CCU once every three year contract period to ensure compliance with contractual obligations. After conducting compliance reviews, the OA summarizes information on each performance indicator targeting the following users: the MA, the OA, CCUs, providers and Care Coordinators. The MA and OA review the statewide performance data during quarterly meetings. The summarized data assists the two agencies with identifying potentially problematic trends and tracks the effects of remediation efforts to improve performance. Similarly, detailed reports for each level of entity are shared quarterly. These reports provide the basis for trend identification and specific areas of problems, leading to remediation. When individual problems with existing provider qualifications and contract compliance are identified, there is an initial effort to resolve the situation. In the case of problems identified through the complaint system, the State requires resolution within fourteen days. For other types of compliance problems, the State makes an initial request for corrective action. This corrective action request is tracked until there is a successful resolution. If there is not successful resolution, the State may take contract action under Rule 240.1665. These actions include 1) suspension of new referrals; 2) fines; or 3) contract cancellation.

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

The MA and OA meet quarterly to discuss summary reports that include statewide data and corrective action that has been taken by the OA. This provides an opportunity for both agencies to identify trends and issues, and to discuss remediation steps.

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

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

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

Additionally, the MA has developed queries within its Data Warehouse to review provider qualifications. The MA pulls reports by waiver provider type for both licensed and unlicensed providers to assure that they initially met and continue to 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 are reviewed and discussed annually at one of the quarterly Quality Management 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 a newly waiver provider fails initial IMPACT screening requirements, the MA informs provider of disposition of application and does not enroll into the Medicaid system. OA is also notified of findings.

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

C3: The CCU will be notified of the unmet contractual requirement. The CCU must meet the contractual requirement within 30 days.

C4: The training requirements will be completed. The OA may require a plan of correction from the in-home service (homemaker) provider for how training requirements will continually be met for all in-home staff (homemaker). Remediation within 60 days.

C5: If the OA/MCO Care Coordinator has not met required credentials or completed the required initial training they are prohibited from performing Care Coordinator functions until completed. The OA/MCO Care Coordinator will gain the required credentials and/or complete the required training within 60 days.

C6: If the OA/MCO Care Coordinator credentials lapse or does not complete the required training they are prohibited from performing Care Coordinator functions until completed. The OA/MCO Care Coordinator will regain credentials and/or complete the required training within 30 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 HCBS 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 (PCP)

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

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

Minimum qualifications for Care Coordinators:

1) Be an R.N, or have a B.S.N, or have a B.A./B.S. degree in social science, social work or related field. One year of program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education up to and including four years of experience replacing a baccalaureate degree; or,
2) Be an LPN with one year of program experience which is defined as assessment of a provision of formal services for the elderly and /or authorizing service provision; or
3) Be waived for persons hired/serving in this capacity prior to December 31, 1991. Provision of a waiver for care coordinators hired prior to December 31, 1991 was based on their years of experience. These care coordinators must maintain certification for a case manager and must also follow in-service requirements.

Care Coordinators must also complete the following OA sponsored training:

1) Preliminary Care Coordination certification training that must occur prior to conducting customer assessments;
2) Care Coordination Certification training and successfully pass the required exam within six months of completing Preliminary training; and
3) Recertification training within each 18-month anniversary of each previous certification.

Care Coordinators must also complete 18 hours of documented in-service training on aging related subjects within each calendar year. For partial years of employment, training shall be prorated to equal 1.5 hours for each full month of employment. Documented participation for in-house staff training and/or local, state, regional, or national conferences on aging related topics in addition to the Department sponsored Preliminary, Certification and Recertification training will qualify as in-service training on an hour-for-hour basis.

For customers enrolled in an MCO, the MCO Care Coordinators are responsible for person-centered planning (PCP) development. Qualifications for the MCO Care Coordinators may slightly vary within each of the MCOs however, minimally each MCO must meet the qualifications outlined in the OA's Administrative Rules for Care Coordinators (Administrative Rule 220.605) MCO Care Coordinators are assigned based on customer need and identified risk. At minimum, qualifications include the following license or education level:

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

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

MCO Care Coordinators must be trained on topics specific to the type of HCBS waiver customer they are serving. For the Elderly Waiver, training must include Aging related subjects.

☐ **Social Worker**
Specify qualifications:

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

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. *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:*

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D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Supports and information available to customer

OA Process:

The PCP begins with an assessment and re-assessment conducted by an independent Care Coordinator from the local Care Coordination Unit, and not linked to any provider of service. Effective 1/1/2020, the OA became in full compliance with implementation of federal PCP requirements that encompasses a holistic approach. This included revision of the comprehensive assessment to encourage increased customer/authorized representative involvement in development of the PCP and development and usage of the Participant Bill of Rights brochure. Significant training was provided to Care Coordinators on the PCP process and all subsequent new Care Coordinator training has been updated to ensure the OA is in compliance. The CCP Rule has been promulgated to include the PCP process requirements. OA monitoring tools have been revised to ensure PCP requirements are being included.

Routine practice of the OA Care Coordinator includes asking the waiver customer who he/she would like to attend their PCP development session as an authorized representative. As the date and time is set for the PCP and discussion, the OA Care Coordinator is to make every accommodation possible to satisfy and include all persons identified by the customer. It is expected that all conversations between the OA Care Coordinator and the customer are customer-focused, constantly reinforcing that planning is a collaborative effort, enabling the waiver customer to lead the process to the best of his/her abilities and that the outcome of the process is a PCP that is holistic, owned, is agreed to by the customer and is reflective of their needs, preferences, person-centered goals, safety, welfare, and health status.

In addition, the language in these documents articulate the ability of the customer to include all persons chosen by the customer to be included at all informational gathering, assessment and reassessment meetings. Language states that meetings should occur at times and locations convenient to the customer, with the understanding that to fully assess the customers' needs, is the assessment needs to be completed in their home environment and that the waiver customer is in essence the driver of the PCP development. Language states that the conversation between the waiver customer and the Care Coordinator is to be goal centered.

As noted above, the holistic person-centered approach is designed for care coordination to encompass the comprehensive assessment of the customer's situation and circumstances related to all factors contributing to health, welfare, safety, community integration, quality of life, ability to live independently in the community and the customer's vision for his/her quality of life. The CCP utilizes the assessment tool for this holistic approach. The process - utilizes a tool that includes a review of the customer's environment in the community, physical, cognitive, psychological/emotional, and social well-being. It also includes identification of existing support systems and the need for further evaluation(s) by other disciplines. The assessment covers eleven domains; customer demographics, physical health history, behavioral health, Determination of Need (DON) & Mini-Mental Status Exam (MMSE) evaluation, medications, nutrition, caregiver, transportation, environmental, financial and legal. Information collected in the assessment is used to help the Care Coordinator and the customer form the POC. Risk factors, such as depression, alcohol and substance abuse, medications, caregivers, health, falls and behaviors, are identified and addressed throughout the domains of the assessment tool. Care Coordinators are trained to discuss potential risks with the customer and work together to develop a PCP that will minimize or eliminate risk.

The comprehensive assessment prompts the Care Coordinators to ensure all areas of a holistic assessment are captured and includes what the customer hopes to achieve from the delivery of waiver services, as well as other available options. The PCP that emerges from this assessment and conversation is one that encompasses all customer needs, desires, goals and vision and links the customer with an array of options, not just those programs and services that are components of the waiver.

The PCP is the result of this comprehensive assessment and it captures the waiver customer's life goals and desires. It identifies supports--both waiver services and non-waiver services to assist the customer in actualizing these goals and desires. The written documentation in the development of the PCP and other assessment forms utilized during the assessment/reassessment processes demonstrate that the waiver customer exercised choice in the decision-making process. Once the PCP is developed by the care coordinator and the customer, it is signed by the customer, the care coordinator, and sent to all providers for signatures. A copy of the PCP is provided to the customer and all providers listed on the PCP.

The Home Care Consumer Bill of Rights which was enacted August 15, 2014 into State law outlines the State's

commitment to assuring the rights of all home care customers, emphasizes participation in planning, self-determination, choice, dignity, and individuality. This Consumer Bill of Rights is to be provided to and discussed with the customer at all assessments and sessions where planning occurs. Assessments and Reassessments are required to be completed at least annually and based upon changes in customer circumstances such as a recent hospital visit, loss of a caregiver and/or significant changes in the customer's health.

MCO Process:

The same processes of how an assessment and/or reassessment described above by the OA is expected of care coordination provided by MCOs. MCO Care Coordinators are expected to engage the customer and assure that he/she directs the process as much as possible by asking and encouraging at all levels of the assessment, reassessment and PCP processes. All accommodations are to be given to anyone he/she wishes to include in the discussions and meetings to develop a holistic PCP.

The MA strengthened language in the MCO contract with an amendment signed 12/18/19. The new language added PCP processes to the contract, including 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 includes provisions that the HCBS Setting Rule is met when applicable.

The engagement and inclusion of the customer and those that he/she designates to be included in the process requires training and expertise by the MCO Care Coordinator. The MCO assessment tools and those given to them by the OA prompts the Care Coordinators to ensure all areas of a holistic assessment are captured and that it reflects the goals, desires, and needs of the customer. The resulting PCP reflects what the customer hopes to achieve and meets the customer's expectations to the best of ability of available programs and services that include waiver and non-waiver programs and services. The PCP that emerges from this assessment and conversation is one that encompasses all customer needs, desires, goals, and vision and links the customer with the whole array of options, not just those programs and services that are components of the waiver.

The MCOs have assessment tools that contain components that are used to elicit and achieve holistic and comprehensive information from the customers to support a PCP. 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 review the State's assessment/Level of Care instruments, conducted by the OA and use it when developing the service plan. In addition, the MCO Care Coordinator's assessment secures information that include the customer's strengths, needs, personal goals and desires, levels of functioning and risk. The customer's PCP is to be reviewed within 90 days of initial implementation of the service and reassessed as needed. MCOs are required to have the health risk assessment completed within 90 days of enrollment. A reassessment is to occur whenever the customer requests a reassessment, when there is a change in the customer's condition or, at a minimum annually. The Contract requires contact visits in the home no less than once every 90 days. All Care Coordinators are trained to discuss potential risks with the customer and work together to develop a PCP that will minimize or eliminate risk. Through the assessment and PCP process, the customer's goals and the strengths and barriers to achieving these goals are identified. Once the PCP is developed by the care coordinator and the customer, it is signed by the customer, the care coordinator, and sent to all providers. A copy of the PCP is provided to the customer and all providers listed on the PCP.

MCO Care Coordinators are also required to enable as much choice as possible with the MCOs offering options of providers to accommodate customer preferences and choice. MCOs must offer contracts to all willing and qualified certified CCP providers in the contracting area so long as the Provider agrees to the MCO's rate and adheres to the MCO's quality assurance requirements.

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

The customer's right to determine who is in included in the process is articulated in the Home Care Consumer Bill of Rights. This is to be given to all customers at the time of assessment and reassessment. Also, as described in (a) above for both the OA Care Coordinators and those of the MCOs, Care Coordinator's practice requires that they routinely inquire and document the customer's authority to determine who is included in the process. This is documented in the

PCP.

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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):

The State is committed to implementation of a person-centered planning process. The Care Coordinators are trained to include the customer in every aspect of the assessment and service plan development, including providing the customer and his/her representative with the opportunity to lead the planning process.

For the OA, the Care Coordinator contacts the customer or authorized representative, usually by phone, prior to the scheduling of the assessment. Assessments are generally conducted in the customer's residence except for reassessments of Adult Day Service (ADS) customers, which may be conducted at the ADS site. The Care Coordinator schedules the visit around the customer and other parties that the customer wishes to have included.

a) Development of PCP, participation in process, and timing of the plan:

OA Process:

The OA Care Coordinator conducts a face-to-face comprehensive assessment of the customer. The assessment contains a "goals of care" section where the customer expresses his/her goals, which include those related to service needs, overall life goals or desires and their expectations for care. Goals are holistic and are not restricted to only needs that will be addressed by waiver services. For example, if the waiver customer voices a desire to attend a house of worship or to go to lectures at the library, these should appear under goals and be articulated in the PCP.

Customers and anyone they wish to include are to have an active role in the development of the PCP. This includes choosing services and service providers. The face-to-face assessment is conducted in the customer's residence as this is most convenient for the customer and enables the Care Coordinator to see the customer function in their home environment. Reassessments for Adult Day Service customers, if necessary, may on occasion take place at the provider setting if it is determined that an assessment in the home is not an option. Changes to location are to meet the customer’s needs and are not for the convenience of CCU Care Coordinators.

In terms of timing, initial assessments, including eligibility determination, must be completed with customers within 30 calendar days of request for services unless the delay is caused by the customer. Reassessments must occur within 30 calendar days of customer request. Waiver service providers have a maximum of 15 calendar days to begin providing services to the customer from the date of the written notice of eligibility to the customer. These timeframes are maximums, and in most cases the process is completed much sooner. For those customers that are in imminent risk of being placed in a nursing home, Care Coordinators can request that the customer receive interim services (for new customers) and Temporary Services Increases (TSIs) for existing customers requiring a reassessment. Interims and TSIs require service providers to start services within 2 business days from the date of the customer notice of eligibility or continued eligibility.

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. 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 and 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:

In (a) above, the process in all assessments is to have the customer articulate his/her needs, goals, and desires. 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. The CCP utilizes the Comprehensive Care Coordination (CCC) assessment tool for this holistic approach. The CCC tool includes a review of the customer's environment in the community, physical, cognitive, psychological, and social well-

being. It also includes identification of existing support systems and the need for further evaluation(s) by other disciplines. The CCC tool covers eleven domains; participant demographics, physical health history, behavioral health, Determination of Need (DON) & Mini-Mental Status Exam (MMSE) evaluation, medications, nutrition, caregiver, transportation, environmental, financial and legal. Information collected in the CCC assessment is used to help the Care Coordinator and the customer form the PCP. Risk factors, such as depression, alcohol and substance abuse, medications, caregivers, health, falls and behaviors, are identified and addressed throughout the domains of the CCC assessment tool. Care Coordinators are trained to encourage the customer to direct the assessment as much as possible, to discuss potential risks, and work together to develop a PCP that will minimize or mitigate/eliminate the risk.

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. These tools are both internal and adopted by the MA, as well as 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. The MCO Care Coordinators, like the OA Care Coordinators, 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 HFS, the External Quality Review Organization (EQRO) reviews assessments as part of its pre-implementation record review, onsite post-implementation record review, as well as in quarterly record reviews, to ensure the assessments meet contractual requirements.

c) Informing customer of services available under the waiver:

OA Process:

After the Care Coordinator determines eligibility and completes the CCC assessment, they discuss with the customer the array of services, regardless of funding sources, which are available to them and for which they are eligible. The array of services also includes the customer's goals that may not be met by a waiver or other formal services. It is the Care Coordinator's responsibility to explain all service options to the customer, including, but not limited to waiver services. Care Coordinators are required to go through Case Management training that includes training on comprehensive care coordination. This training outlines services that are available through other state and federal agencies, local entities, and charitable organizations. The customers are required to sign the CCC assessment to ensure that it adequately represents their goals for care and that the PCP is designed as they want. Customers also sign a program consent form verifying that service options were explained to them and that they had freedom of choice in choosing their service and their service providers.

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 PCP addresses customer goals, needs (including health care needs), and preferences:

OA Process:

The CCC assessment identifies unmet needs in 11 domains. The tool includes a summary section at the end of each domain that summarizes the needs identified by the Care Coordinator and customer during the assessment. These summary sections are then identified on the customer's goals of care and PCP. The Determination of Need (DON) assessment identifies level of need and unmet need for care. The DON assesses 15 areas including; eating, bathing, grooming, dressing, transferring, continence, managing money, telephoning, preparing meals, laundry, housework, outside the home, routine health, special health and being alone. Any unmet needs on the DON must be addressed on the PCP. Customer's preferences are obtained throughout the entire assessment process including during the development of the PCP. Customers must sign the CCP consent form indicating that they were given a choice of services and a choice of provider agencies.

MCO Process:

Comprehensive assessments are developed by the MCOs. The MCO contract specifies expectations for waiver customers, including content of and purposes for Customer Care Plans and HCBS Waiver PCPs (for customers receiving HCBS Waiver services).

After the comprehensive assessment has been completed by the MCO, and the array of services have been presented to and discussed with the customer, the MCO's Care Coordinator, the customer and/or their representative(s) formulate an individualized 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. The outcome is the PCP. As this is customer-centric, personal preferences are integral to the development of the PCP, such as cultural preferences, living arrangements, and provider preferences for language and time of services. 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 care coordination of healthcare needs and long-term services and supports. MCOs develop a holistic PCP and are responsible for monitoring its implementation, along with the customer. 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 make sure the assessments meet contractual requirements.

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

OA Process:

The CCC is completed at the initial assessment and at least annually thereafter. This tool ensures that no duplication of services exists. The PCP includes all other services the customer is receiving, regardless of funding source. The PCP is then sent to each waiver provider listed on the PCP so that the providers are aware of additional services or assistance in the home. Providers are trained to report any changes in the customer situation to the OA's Care Coordinator including a disruption of other, non-waiver services. Identifying all agencies in the home on 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.

MCO Process:

Services are coordinated by the customer's assigned MCO Care Coordinator, who is responsible for the identification, authorization, and assignment to the responsible service provider in coordination with and direction from the customer and/or their representative. MCO Care Coordinators are expected to offer information on non-waiver services to the customer and make referrals as appropriate on behalf of the customer. All non-waiver services should be included on the PCP created by the MCO Care Coordinator in conjunction with the customer.

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

OA Process:

The OA mandates that upon the initial assessment and every assessment thereafter, the OA Care Coordinator must provide the Rights and Responsibilities brochure to the customer. In addition, a Participant's Bill of Rights with information about Participant Person- Centered Planning and rules related to settings. The brochure outlines the responsibility of the customer and in regards to the Bill of Rights, those responsibilities of the MA and OA as it relates to

receiving services. The OA mandates that 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 mandate was met. Provider agencies are also mandated to notify the OA Care Coordinator of changes in the customer's status. OA policies, rules, and training outline the responsibilities of the OA Care Coordinator. These responsibilities include development and continuous 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 Participant's Bill of Rights, as described above, which contains information about Participant Person-Centered Planning and rules related to settings, is included in the documents provided to customers receiving waiver services. This brochure outlines the responsibility of the customer and in regards to the Bill of Rights, those responsibilities of the MA as it relates to the receiving services.

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

OA Process:

OA administrative rules require that customers receive a new assessment at least annually; whenever requested by the customer/authorized representative; or whenever the customer may have experienced a change in his or her needs that indicate the need for a reassessment to ensure continued eligibility; within 30 calendar days of customer request or within 15 days following discharge from a hospital or other institution. PCPs are reviewed and adjusted during each assessment. Customers may request a change to the PCP at any time. During assessments, the OA's Care Coordinator educates the customer to call the CCU to request a new assessment or to report any changes in their living or medical situation that may affect their services.

PCPs can be created or adjusted in-between assessments to meet the customer's immediate needs. Whenever there is a significant change in level of service 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 OA's 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 OA's 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 OA's Care Coordinator is responsible for providing clear direction to the customer regarding appeal rights whenever a reduction, termination, or suspension in service(s) occurs. The appeal rights and processes are summarized in the Rights to Appeal brochure that the customer receives at the initial assessment, and each reassessment thereafter. If the customer appeals, within 10 days from the date of the Adverse Determination Letter given to the customer, the services will remain intact until the appeal process is exhausted, including the State Fair Hearing.

MCO Process:

Administrative Rules require that customers receive a new assessment at least annually; whenever requested by the customer/authorized representative; or whenever the customer may have experienced a change in his or her needs that indicate the need for a reassessment to meet their needs. During assessments, the MCOs Care Coordinator educates the customer to call the MCO Care Coordinator to request a change in the PCP if the customer's situation or needs change in-between assessments. The customer is educated to notify the MCO Care Coordinator any time there is a change in their living or medical situation that may affect their need for services. PCPs can be created or adjusted in-between assessments to meet the customer's immediate needs. Whenever there is a significant change in level of service needs or functioning (for example, hospitalization significantly impacting the customer's level of functioning), a new assessment is to be completed and additional services provided as needed.

The customer is in the center of the PCP process. The MCO Care Coordinator completes a comprehensive assessment to identify the customer's strengths, needs, 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 MCO Care Coordinator obtains the customer's signature of agreement on the PCP and offers the customer a choice of providers to fulfill the services.

The MCO's Care Coordinator is responsible for providing clear direction to the customer regarding appeal rights whenever a reduction, termination, or suspension in service(s) occurs. The appeal rights are summarized in the PCP that the customer signs at the initial assessment, and each reassessment thereafter. If the customer appeals, within a certain time-frame, the services will remain intact until the appeal process is exhausted, including the State Fair Hearing. In order for services to continue during the appeal, the customer must make that request within 10 days of the Adverse Determination Letter. The member handbook/inserts that are provided to the customer also provide information on appeal rights and processes.

For reassessments, MCOs analyze reports and data on a monthly basis to identify risk level changes for their customers. High risk customers have PCPs updated every 30 days and moderate risk members have PCPs updated every 90 days. At a minimum, MCOs shall conduct a health risk reassessment annually for every member with a PCP. All HCBS customers, including Elderly Waiver customers, have a PCP.

Appendix D: Participant-Centered Planning and Service Delivery

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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 Care Coordinators assess for customer needs, evaluate current customer risks and work with the customer to identify the resources and strategies to mitigate these risks through the linkage and delivery of services ultimately to prevent institutionalization and be successful in community residency. For example, if the customer is at nutritional risk, homecare services or Older Americans Act funded home delivered meals may be part of the of PCP to mitigate this risk.

The comprehensive assessment tool requires the Care Coordinator and customer to discuss other factors or services beyond waiver services that may help mitigate risk.
This may include behavioral health services to address depression, anxiety and abuse of alcohol or other substances including illegal substances and medications; caregivers; physical health; mitigation to prevent occurrences and risks of falls are explored and addressed.

The comprehensive assessment includes a back-up plan to the PCP. The back-up is specific to the customer's needs and preferences. Care Coordinators are trained to understand that a sufficient back-up plan is not to just rely on calling 911, but rather one that utilizes other formal social service agencies, as well as family, neighbors and friends, and assistive technology devices. Together the Care Coordinator, customer and anyone else the customer elects to be engaged in the process discuss the availability of both formal and informal options in the event that the authorized services in the PCP are not provided and establish a back-up plan to meet the customer’s needs. The Care Coordinator assists the customer with posting the back-up plan in a location that is accessible and visible to the customer and other providers that support the customer. The back-up plans include the names and phone numbers of persons and agencies who are available to immediately assist the customer if needed.

Additionally, per CCP rule [240.1510 q], provider agencies are responsible to have a policy for an all hazards disaster operations plan including but not limited to medical emergencies, home or site-related emergencies, participant-related emergencies, weather-related emergencies and vehicle/transportation emergencies. For example, in-home service (homemaker) agencies train their home care aides to make additional meals for storage and reheating during times of inclement weather just in case a home care aide cannot access a customer due to inclement weather.

MCO Process:

For customers enrolled in an MCO, the assessment for potential risk is included in the PCP development process. The MCO Care Coordinator at the MCO is expected to incorporate and utilize the same strategies as described above in the development of the PCP. In addition, the MCOs use predictive modeling reports and other surveillance data, including claims data to assess risk and identify risk level changes.

The MCO Care Coordinator completes a comprehensive assessment and care plan 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 behavioral health conditions; 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 customer's ability to live as safely and independently as possible. All risks are identified and discussed while developing the PCP. Through service planning interventions, identified risk(s) are mitigated and barriers are addressed with interventions which are mutually agreed upon by the customer and the MCO.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

OA Process:

The OA notifies all CCUs and Care Coordinators of all certified contractual providers that provide services in their geographic service areas. The State requires that freedom of choice be afforded to all customers in the waiver. The OA Care Coordinators meet with the customers to discuss their goals and desires and develop the PCP. It is the Care Coordinator's role to provide information about the available service providers to each customer and to answer any questions that arise. If the customer has no preference of a provider agency, then the OA Care Coordinators are required to utilize a rotating service provider list. This list includes all service providers in the geographic service area and is maintained at each local CCU office. Customers must sign a Participant Consent Form that indicates that they were afforded freedom of choice or that they requested a provider agency be assigned to them from the rotation list. Information of available providers is available on the OA's website under the Provider Profile application for customers and their families to review available service provider agencies and service specific details about each provider. Each service provider is also encouraged to have its own brochures and advertising material available upon customer or OA Care Coordinator request. Customers and families are encouraged to visit Adult Day Service (ADS) providers before agreeing to services at the ADS. Customers/authorized representatives identify the provider chosen and sign the Participant Consent Form and Client Agreement to verify that the providers selected.

MCO Process:

For customers enrolled in an MCO, the MCO Care Coordinator assists the customer in obtaining information and selecting from among qualified certified CCP providers of the waiver services in the PCP. The State requires that freedom of choice be afforded to all customers in the waiver.

The MCO Care Coordinators meet with the customers to discuss their goals and desires and develop the PCP. It is the MCOs Care Coordinator's role to provide information about the available services and service providers to each customer, and to answer any questions that arise. The OA notifies all MCOs and MCO Care Coordinators of all certified contractual CCP providers that provide services in specific geographic service areas. The CCP provider agency and the MCO work together to establish a contract between their agencies so waiver services can be provided to waiver MCO customers. The MCO Care Coordinator will assist the customer through the provider network supplying provider information relevant to the services selected by the customer on their PCP and available in the customer's service area. If the customer has no preference of a provider agency then the MCO Care Coordinators are required to utilize a rotating service provider list. This list includes all service providers in the geographic service area of the customer. Customers always have first choice on the providers they select to meet their needs. MCO Care Coordinators support the customer in selecting a provider to meet their needs if the customer does not have a preferred provider identified. The MCO maintains a current list of qualified and contracted CCP service providers which are made available to customers upon request. The customer is also educated that the MCO's provider list is available on the MCO's website.

MCO Process:

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

It is the MCO’s Care Coordinator's role to provide information about the available services and service providers to each customer, and to answer any questions that arise. The MCO will assist the customer through the provider network supplying provider information relevant to the services selected by the customer on their PCP and available in the customer's service area. Customers always have first choice on the providers they select to meet their needs. MCO Care Coordinators support the customer in selecting a provider to meet their needs if the customer does not have a preferred provider identified. The MCO maintains a current list of qualified and contracted service providers which are made available to customers upon request. The customer is also educated that the MCO's provider list is available on the MCO's website.

MCOs must have contracts in place with a sufficient number of such Providers within each county in the Contracting Area to assure that the Affiliated Providers served at least eighty percent (80%) of the number of customers in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into

contracts with at least two (2) of such Providers, so long as such Providers accept Contractor's rates, even if one (1) served more than eighty percent (80%) of the customers, unless the MA grants Contractor an exception. It is the State's goal that this will insure choice on behalf of the waiver customers.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The OA and the MCOs have day-to-day responsibility for completion and approval of PCPs; however, the MA, through its Quality Improvement System, reviews PCPs through a sample process as described below.

The OA completes a Quality Improvement Review of each contracted CCP provider and Care Coordination Unit at least once every contract cycle of three years. This ongoing administrative activity allows the OA to ensure that providers and CCUs are adhering to the rules, regulations, policies, and procedures of the CCP. Prior to the review, the OA chooses a random stratified sample from the agency's billings in electronic CCP Information System (eCCPIS). The standard for determining the sample size is based on the number of customers served by the CCP provider per the agreement number. The sample includes both customers in the waiver program and non-waiver customers covered by General Revenue funding. Prior to the review, the OA checks the CERA (Critical Events Reporting Application) database to review any complaints/concerns for each CCU and provider agency(ies).

The MA reviews a sample of PCPs when monitoring the OA. During these reviews, PCPs are reviewed for compliance with state and federal regulations. Reports of findings are shared with the OA and recommendations for improvement are made. The OA responds to the MA reports both on an individual and systemic basis. The OA provides follow up on all MA reviews of CCUs and provider agencies to ensure corrective actions and remediations have occurred within established timeframes. Discussions on Quality Management review findings and trends are discussed during quarterly meetings between the MA and OA.

For the MCOs, the MA selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The MA uses a proportionate sampling methodology with a 95% confidence level and a 5% margin of error for both the OA and the MCOs.
Once the MA selects the sample, it is provided to the MA's External Quality Review Organization (EQRO), the entity responsible for monitoring the MCOs. The OA and the EQRO determine a review schedule, based on the sample and performs onsite record reviews to assess compliance with the PCP performance measures. For the MCOs, the EQRO sends a report of findings to the MA and the MCOs. The MCOs are required to remediate findings within required timelines, and report remediation activities to the MA, at least quarterly. The MCOs report on both individual and systemic remediation. The MA has quarterly meetings with the MCOs during which quality improvement activities are reviewed and remediation approaches and trends are discussed.

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.

OA Process
The CCU/Care Coordinator is responsible for monitoring the implementation of the PCP and the customer's health, safety and welfare.

a) Care Coordinators and customers develop the PCP together during the initial assessment and at each reassessment the PCP is reviewed and adjusted as needed. Waiver customers are provided with the opportunity to lead the PCP process. The OA administrative rules require that customers receive a new assessment at least annually, when there is significant change, within 30 days of customer request and within 15 days of discharge from a hospital or institution.

The CCC assessment addresses all aspects of customer function and supports. The OA Care Coordinator identifies services needed and makes the appropriate referrals, as agreed upon by the customer and the OA Care Coordinator during the PCP process. Referrals are made for a variety of services including those outside the services offered in the Ederly waiver. OA Care Coordinators are trained to utilize local and regional funded services in addition to waiver services whenever appropriate. Examples of additional services include home delivered meals, medication management, flexible senior services, respite care, transportation, and medical and home health services.

b) The CCUs/Care Coordinators monitor the provision of services through customer contact, intensive case monitoring as applicable, and satisfaction surveys.

The customer, authorized representative, or provider agency can request a follow-up by the Care Coordinator. When problems are detected, PCPs can then be revised or new a plan can be implemented. For those customers with complex PCPs requiring more intensive follow-up to ensure that the additional referrals are in place and working properly, the program allows OA Care Coordinators to provide Intensive Case Work and Intensive Monitoring.

The CCC assessment triggers the need for more intensive case monitoring. For example, a customer who has a complex PCP utilizing service providers both within the waiver and outside the waiver would be appropriate for Intensive Case Work. This allows the Care Coordinator to devote more time to making the appropriate referrals within the community and making sure that the customer has a complete PCP that will meet their needs. Intensive Monitoring is authorized for up to three months to allow the Care Coordinator time to ensure that the PCP is working and is meeting the customer’s needs.

c) Care Coordinators are required to meet face to face with waiver customers every six months, and more often as needed. Intensive monitoring is available for customers that require more frequent case management and monitoring.

It is the customer's responsibility to notify the Care Coordinator of any change in status or to request a change to the PCP. Customers can request a change to the PCP at any time. Provider agencies are mandated to notify the Care Coordinator or CCU of changes in the customer's status. OA policies and training outline the responsibilities of the Care Coordinator for developing and monitoring the PCP. Care Coordinators can also authorize the Intensive Case Work or Intensive Monitoring for customers that require more frequent management. Intensive Monitoring requires a face-to-face meeting at least once in each month that it is billed.

For customers enrolled in an MCO, the MCO Care Coordinator is responsible for monitoring PCP implementation, including whether services and supports meet the customer’s needs and back up plans are adequate.

For the MCOs, the primary avenue to monitoring the customer's needs and PCP is the completion of the comprehensive assessment with the customer. The MCO Care Coordinator and the customer work collaboratively during the initial assessment and at each subsequent reassessment on the PCP process. The MCO Care Coordinator is responsible for monitoring the implementation of the PCP, the availability and effectiveness of identified services and supports, and the customer's overall health and welfare.

The MCO Care Coordinator works with the customer to identify the agreed upon services to include in the PCP and coordinates the service delivery process based on the customer’s needs. MCO Care Coordinators also identify services, supports, or activity outside of the waiver benefit that may support the customer's PCP. In addition to being completed at the initial assessment and reassessment visits, the PCP is also reviewed in-between assessments if there is a change in service needs or a change in customer’s health condition.

Service provision and customer satisfaction are continually monitored at each assessment. During each reassessment

visit, the Care Coordinator reviews the PCP to ensure that services are furnished in accordance with the PCP and that the services provided by the service provider are meeting the needs of the customer. A new PCP will be created at each reassessment to capture customers review and agreement with the PCP even if needs or services have not changed. The need for any additional non-waiver-based services is also discussed. The MCO Care Coordinator provides on-going education to the customer about reporting any issues with the provision of services and their service providers. The customers are encouraged to call the MCO Care Coordinator to assist in resolving issues identified by the customer.

The MCO Care Coordinator also reviews the backup plan to ensure it is still in effect and if the backup plan was utilized, it is discussed with the customer to ensure its effectiveness. The PCP, service providers, backup plan or referrals to non-waiver services may be made or modified to ensure the customer's needs are adequately met based on these discussions.

The MCOs have a process to implement a method of monitoring its Care Coordinators to include, but not be limited to conducting quarterly case file audits and quarterly reviews checking that PCPs are completed with each assessment or in between assessments if customer's needs have changed, service listed on the PCP address customers need identified in the assessment, back-up plans are created for customers receiving in-home (homemaker) services and are comprehensive. The MCOs have a process to compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the MCO Care Coordinator has taken to resolve identified issues. The MCOs will provide the MA the results of their discovery, remediation, and any systems improvement activities during quarterly quality improvement meetings. Remediation will occur both on an individual and systemic basis.

Through its contract with the EQRO, the MA assures that the MCOs are complying with contract requirements and the waiver assurances for monitoring PCPs. Customers enrolled in the MCO will be included in the overall representative sampling methodology used for the evidentiary reporting of assurances. The MCOs will be required to report event and other data to the MA where sampling methodology is 100%. MA oversight will include onsite or desk audit validation in these areas.

The MA selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The MA uses a proportionate sampling methodology with a 95% confidence level and a 5% margin of error for both the OA and the MCOs. The methodology will be adjusted when new MCOs are enrolled to ensure proportionate sampling across all operating entities.

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
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:
D4: Number and percent of OA and MCO customers who receive in-home service (homemaker) whose PCP includes a back up plan. N: Number of OA and MCO customers who receive in-home service (homemaker) whose PCP includes a back up plan. D: Total 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**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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:
D5: Number and percent of OA customers who received face-to-face contact by their OA Care Coordinator every 6 months to monitor service provision or gaps in service delivery. N: Number of OA customers who received face-to-face contact by their OA Care Coordinator every 6 months to monitor service provision or gaps in service delivery. D: Total number of OA customers reviewed.

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

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver 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 PCP updated every 12 months. N: Number of OA and MCO waiver customers who have their PCP updated every 12 months. D: Total number of OA and MCO waiver customers with PCPs due during the period reviewed.

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

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

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
D9: Number and percent of OA and MCO customers who received services in the

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D10: Number and percent of OA and MCO records that indicate choice was offered between waiver services and institutional care; and between/among services and providers. N: Number of OA and MCO records reviewed that indicate choice was offered between waiver services and institutional care; and between/among services and providers. D: Total number of OA and MCO records reviewed.

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

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

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 PCPs do not address required items, the OA/MA will require the PCPs be corrected and the OA/MCO will provide training of Care Coordinators. Remediation must be completed within 60 days.

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

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

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

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

D6: MA will require customer be contacted and provide training 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/MCO will require that the PCPs be corrected and provide training to the OA/MCO Care Coordinator. 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: MCO	☐ **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 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)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Fee-For-Service
Any customer who applies for or receives waiver services has the right to appeal a decision, action or inaction of the OA, a Care Coordination Unit (CCU) or a provider. The customer is informed by the CCU of his/her right to appeal any action taken regarding services or eligibility. In addition, the customer is provided with a Right to Appeal brochure at the time of the initial home visit and upon every reassessment which details the rights to appeal and outlines the appeal process.

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

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

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

At each assessment, the Care Coordinator is required to provide and review brochures, including a brochure regarding the customer’s right to appeal. Customers receive written notice regarding the outcome of each assessment, which includes information regarding the customer's right to appeal as well as the process to do so.

Per 89 ILAC 240.430, within 60 calendar days after the date of receipt of the Notice of Appeal form, the OA shall conduct an informal review and issue an Appeal Findings Notice that may be delayed pending an extension of time requested by the customer. When the informal hearing is complete, an Appeal Findings Notice with the outcome is issued to the customer, with copies sent to all parties to the appeal. If the appeal is denied, based upon the OA decision resulting from the informal review, the appeal shall automatically proceed to hearing unless the customer/customer's authorized representative withdraws the hearing request in writing. This statement is included on the Informal Review Findings notification sent to the customer/authorized representative. The Appeal Findings Notice includes information on how to request a Fair Hearing.

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

Customers who file an appeal within 10 days of notice of the adverse action are notified that services will continue through the appeal process via the OA Appeal action notice, which states that the level of service is being continued until the appeal is complete. Fair hearing documents, including notices of adverse actions and requests for a Fair Hearing, are maintained by OA.

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

Advocacy
The OA LTC Ombudsman Program (LTCOP) provides services to customers receiving HCBS through the OA or MCO. The LTCOP was initially designed to protect and promote the rights and quality of life for customers who reside in LTC facilities. LTCOP coverage includes seniors aged 60 and older, and disabled adults between the ages of 18-59. The target population includes customers of the Medicare/Medicaid Alignment Initiative, in addition to customers receiving Medicaid waiver services. A Home Care Ombudsman may assist a customer who has requested assistance with grievances and appeals and may represent a customer in a fair hearing. In order to do this, the customer must provide consent by completing the Authorized Representative

Form.

MCO

If a customer enrolled in an MCO is appealing their eligibility to gain access into the waiver or remain on the waiver, the appeal will go through the OA's appeal process as explained above since the OA's CCUs determine eligibility into the waiver. If the customer is appealing the level of services being provided, the appeal will proceed through the MCO's appeal process since the MCO Care Coordinators are developing the PCPs and authorizing services. Customers enrolled in an MCO may file for an internal appeal with the MCO and also have the right to request a fair hearing with final decision being made by the MA. The MA's fair hearings process is the same for all customers, including those enrolled with MCOs. The MA is the final level of Appeal. MCOs are required to have a formally structured appeal system that complies with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. 438 to handle all Appeals subject to the provisions of such sections of the Act and C.F.R. (including, without limitation, procedures to ensure expedited decision making when a customer's health so necessitates). The MA reviews/approves the MCO's Appeal process guidelines, in compliance with MCO Contract Sections 5.30.2.1 and 5.21.1.10.

MCOs inform customers about the Medicaid agency's 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's websites and contained in the MCO Customer Handbooks. Appeal information is also provided whenever a customer requests it. A customer may appoint a guardian, caretaker relative, or provider to represent the customer throughout the appeal process. The MCO shall provide a form and instructions on how the customer may appoint a representative.

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

Each MCO submits a quarterly Grievance and Appeals summary report to the MA. The format of each report is dictated by the MA (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 plans to analyze trends, outliers among plans and to assure that the plans are addressing areas of concern. Records of adverse actions and requests for appeals are maintained by the MCOs for a period of six (6) years, per 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 customers' rights to a Fair Hearing and how to request such. The State's External Quality Review Organization (EQRO) also reviews such documents through a desk review and determines if the MCO is compliant during on-site visits. The State reviews/approves the MCO's appeal process guidelines.

The 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 customer by the MCO's Care Coordinator.

When services are denied, reduced, suspended, or terminated, or choice is denied, the customer is informed via a Notice of Adverse Determination. This notice includes (a) A statement of what action the MCO intends to take; (b) The reasons for the intended action; (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.

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:

For Fee-for-Service (FSS) customers, the OA operates the grievance and complaint system in cooperation with its contracted agencies.

For participants enrolled in an MCO, the MCOs establish and maintain procedures for reviewing grievances registered by customers.

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

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).

Fee-for-service customers file a grievance or complaint, they are informed that filing a grievance or complaint is not a prerequisite or substitute for an appeal and fair hearing. The OA's procedures do not require customers to file an informal grievance prior to exercising their right to appeal. An appeal can be requested by a customer/authorized representative for any action/inaction taken by a CCU, provider, or the OA. 89 III. Administrative Code 240.415 contains a list of these actions/inactions. A customer does not need to file a grievance before starting this process.

At service initiation and at each reassessment, the OA Care Coordinator is required to provide a brochure titled, "Your Rights and Responsibilities." This brochure explains the OA's informal grievance process for customers/authorized representatives. Customers who are dissatisfied with some aspect of service provision may contact the OAs Senior HelpLine (SHL) (via written format or telephone) to file grievances or complaints. The SHL representatives are trained to distinguish the difference between an informal grievance or complaint versus an appeal. If a customer or representative calls the hotline with what is actually an appeal, the customer's appeal rights are triggered. 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.

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

The MCO must have a Grievance Committee for reviewing grievances registered by its customers (MCO Contract Section 5.40.6) and MCO customers must be represented on the Grievance and Appeal Committee.
At a minimum, the following elements must be included in the Grievance process:
-A formally structured Grievance system that is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. Part 438 Subpart F to handle all Grievances subject to the provisions of such sections of the Act and regulations (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. The MA may require that one (1) member of the Grievance Committee be a representative of the MA;
-A summary of all Grievances heard by the Grievance Committee and by independent external reviewers and the responses and disposition of those matters must be submitted to the MA quarterly; and

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

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

The Adult Protective Services Act (320 ILCS 20/1 et seq.) authorized the OA to administer the Adult Protective Services (APS) Program to respond to reports of community-based abuse, neglect, self-neglect, or exploitation. The empowered APS Program provides for intake, investigation, and follow-up of reported incidents. The APS Program is coordinated through 39 agencies located throughout the state and designated by the Area Agencies on Aging (AAA) and the OA. Many of the APS agencies are also CCUs; however, the APS and CCU contracts are separate. APS agencies conduct investigations and work with adults age 60 or older (including those covered by the waiver) and adults age 18-59 with disabilities, in resolving the abuse, neglect, self-neglect, or financial exploitation. Persons can report suspected abuse, neglect self-neglect, or exploitation to the OA by utilizing the APS Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week. They may also call the Senior Helpline at 1-800-252-8966 (voice) or 888-206-1327 (TTY).

Definitions of ANE
The State uses a set of definitions for critical incidents covering abuse, neglect, self-neglect or exploitation and other events that can place an individual at risk. These definitions can be found at 89 ILAC Section 270.210.
--Abuse means causing any physical, mental, or sexual injury to an eligible adult, including exploitation of such adult's financial resources {320 ILCS 20/2(a)}
--Neglect means another individual's failure to provide an eligible adult with or willful withholding from an eligible adult the necessities of life including, but not limited to food, clothing, shelter, or healthcare. This definition does not create any new affirmative duty to provide support to eligible adults. Nothing in the Act shall be construed to mean that an eligible adult is a victim of neglect because of healthcare services provided or not provided by licensed professionals {320 ILCS 20/2(g).
--Physical abuse means the causing of physical pain or injury to an eligible adult
--Sexual abuse means any sexual activity with an eligible adult who is unable to understand, unwilling to consent, threatened, or physically forced to engage in such sexual activity.
--Emotional abuse means verbal assaults, threats of maltreatment, harassment, or intimidation.
--Confinement means the failure by a caregiver to provide an eligible adult with the necessities of life including but not limited to food, clothing, shelter, or medical care because of failure to understand the eligible adults needs, lack of awareness of services to help meet needs, or lack of capacity to care for the eligible adult.
--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 deprivation means deliberate denial of an adult's 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- does not include when the adult has expressed a desire to forego such medical care or treatment.
--Financial exploitation means the use of an eligible adult's resources by another to the disadvantage of that adult or the profit or advantage of a person other than that adult {320 ILCS 20/2(f-1}.

The Illinois Adult Protective Services Act (320 ILCS 20/1) requires personnel of the OA's Area Agencies on Aging and provider agencies to be mandated reporters in cases where the adult is unable to self-report. The OA policy specifically states that if a direct service worker witnesses or identifies a case of possible abuse, neglect, self-neglect, or financial exploitation, they are mandated to personally report the allegations to the designated APS agency or to the OA's Hotline number within 24 hours. State regulations covering APS mandated reporters and timelines for reporting are contained in 89 Illinois Administrative Code (ILAC), Part 270.30.

More information and brochures regarding Elder Abuse Reporting may be found at:
http://www.illinois.gov/aging/ProtectionAdvocacy/Pages/abuse.aspx

Follow-up Actions by the OA can be found at: 89 ILAC, Section 270.240 Intake of ANE or Self-Neglect Reports

Rules may be accessed at the OA's website at:

http://www.illinois.gov/aging/AboutUs/Pages/rules-main.aspx

The second reporting structure, the Critical Event Reporting Application (CERA), was implemented in August of 2018 for the purposes of capturing all critical event reports that are non-ANE related. The CERA is a centralized web-based application that is used to house event reporting forms, assign work, and track follow-up by primary case management entities--the Care Coordination Units (CCUs). CERA access has been granted to and is required of all providers who serve Fee-for-Service customers under the waiver. All provider entities are required to use the CERA system for event reporting when they are first notified (learn) of a reportable event. After any initial event report is entered, the corresponding Care Coordinator's dashboard (working queue) is populated for follow-up. The CERA provides system updates in real-time to all waiver providers involved in the care of the customer for which a report was made.

The CERA (portal) is accompanied by a comprehensive Critical Event Reporting policy, which defines reportable events, follow-up (response) timeframes and procedures specific to event report closure. The Event Reporting policy requires the CCUs and provider network at-large to report and review critical events in a timely manner, actively attempt to mitigate risk(s) associated with their occurrence while implementing risk-mitigation strategies aimed at reducing future critical events.

To further ensure consistent understanding of reportable event definitions, the Critical Event Report policy breaks non-ANE "critical events" into three main categories for which reports are mandatory. The first main category of reportable event is critical incidents (anticipated death, unanticipated death, unanticipated hospitalization, medication error, serious injury, missing person, emergency department visit, property damage, nursing facility placement, fall with injury, fall without injury, special circumstance and contact with law enforcement. Initial reports for critical incidents must be entered into CERA within 7 days of notification, phone contact with customer or emergency contact must be made within 15 days of notification.

The second main category of reportable events is the Service Improvement Program complaint (SIP). SIPs are specific to situations when a customer experiences delayed service start or inability to access waiver services. SIP complaints must be entered within seven days of being notified of issues with services starting or access to obtain services. Contact with the customer or their emergency contact must be made within 15 days of notification.

The third and final category of reportable events is Request for Change of Status. A Request for Change of Status occurs when the condition of the customer changes or there is a change in circumstances which effects the ability of the family and/or caregiver to safely provide support and assistance. Initial reports for Change of Status must be entered into CERA within seven days of notification.

MCOs must comply with both 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, self-neglect, and exploitation; critical-incident reporting regarding any incident that has the potential to place a customer, or a customer's services, at risk, but which does not rise to the level of abuse, neglect, or exploitation; and performance measures relating to the areas of health, safety, and welfare and required for operating and maintaining an HCBS Waiver.

Examples of critical events may include but are not limited to:
• Death
• Falls
• Serious physical injury or abuse
• Hospital admission
• Misuse of funds
• Medication error
• Unauthorized use of restraint, seclusion or restrictive physical or chemical restraints
• Elopement or missing person
• Fires
• Possession of firearms (customer or staff)
• Criminal victimization
• Financial exploitation
• Suicide or attempted suicide

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

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

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Customers and families are provided information from the CCU at the time of the initial assessment and annual reassessment on abuse, neglect, self-neglect, and exploitation and how to report other critical incidents. Training also covers the occurrence of assigned caregiver/workers not showing-up for service delivery. The State requires the Care Coordinator to address with customers issues of privacy, safety, and respect during administration of the State's Quality Assurance survey. These questions occur during the assessment/reassessment process and is specific to each of the Care Coordination and each of the 4 core waiver services (ADS, INH, EHRS and AMD).

The need for public awareness has been addressed through campaigns, such as "Break the Silence" and "Engage to Change". These public awareness campaigns, facilitated through Adult Protective Services, provide information and training about how to prevent, recognize, and report situations involving abuse, neglect, self-neglect, and exploitation of all adults.
The OA developed a brochure for all waiver customers and family members/guardians that explains how to report ANE. The OA amended its consent form to include documentation from the customer that they received a copy of the brochure.

Care Coordinators receive training as part of the OA required training for all Care Coordinators on critical incident reporting and follow-up. Direct care staff are provided training through their employer and new state provider standards have enhanced requirements for staff training about abuse, neglect, self-neglect, exploitation, and mandated reporting requirements.

For MCOs, customers are provided information about how and to whom to report abuse, neglect, self-neglect, and exploitation during assessments and reassessments. The MCOs provide the customer, or their family or representatives, information about their rights, signs of ANE, what to do if they suspect ANE, and protections, including how they can safely report an event and receive the necessary intervention or support. This happens at least quarterly, during either telephonic or face-to-face assessments.

The MCO must train their Care Coordinators and their external-facing employees on ANE and critical incidents. This includes network providers and subcontractors, who must be able to recognize potential concerns related to abuse, neglect, self-neglect, and exploitation. MCOs must also train those entities on their responsibility to report suspected or alleged abuse, neglect, self-neglect, or exploitation. MCOs train entities at outset on these subjects, can retrain when necessary, and post all material online for providers to review. Online material includes how to report ANE to appropriate authorities. Training sessions are customized to the target audience. Trainings include general indicators of ANE and the time-frame requirements for reporting suspected ANE.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The APS and CERA systems are responsible for initial intake of referrals and to notify the OA, the CCU and the Care Coordinator of incidents. Depending on the nature of the incident of Abuse and Neglect, Self-Neglect, and Exploitation (ANE), the customer and/or family members, and providers may be notified. The State has set criteria regarding when notifications are mandatory or are at the discretion of the Care Coordinator.

The OA has established classifications for critical incidents (i.e., Priority I, II, III,) depending upon the nature and urgency of the event. This classification determines whether an investigation needs to occur in the timeframe for conducting that investigation. The definitions and time frames of these levels are located at 89 ILAC Section 270.240.

Timeframes for Response:
The CERA event reporting process is a two-step process which includes entry of an initial event report and follow-up by the care coordination unit within 60 days.
At 60 days, critical incident reports, including SIPS, must be closed by the Care Coordinator, and documented in the “60-day review summary”.

On a change of status, follow-up with the customer or their emergency contact must be made within 7 days and the issue must be resolved/closed through completion of the “60-day review summary”.

For instances of alleged provider or CCU action/inaction leading to reported death or injury (but not due to suspected abuse or neglect), a verbal report must be submitted within twenty-four (24) hours to the OA's Division of Home and Community Services, Office of Community Care Services. The Provider or CCU must immediately follow-up on any such allegation and provide a written report to the OA’s Division of Home and Community Services, within five (5) business days of the incident.

When a customer death or injury resulting in the need for medical care occurs during the provision of services, the Provider must notify the CCU and the Division of Home and Community Services within 5 business days of the incident. Upon notification from the Provider of an incident, the CCU investigates the circumstances by completing follow-up phone calls to the customer/authorized representative and any actions taken because of these conversations. The CCU must document these follow-up contacts and submit documentation to the Division of Home and Community Services within 10 business days of the incident. Upon receipt of injury and/or death reports from the Provider and CCU, Division of Home and Community Services staff will maintain follow-up communication with both agencies if pertinent activity either exists or is necessary.

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 with the following time frames:
•Priority One – Reports of abuse or neglect where the alleged victim is reported to be in imminent danger of death or serious physical harm. The caseworker must make a face-to-face visit within 24 hours.

•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 State requires that all reports are investigated with initial contact based on assigned priority. APS investigates all reports and with consent, will put interventions in place to address the health, safety, and welfare of the alleged victim. The State's Office of Adult Protective Services' regulations also require certain response timelines by the ANE agency.

The CERA system also tracks the status of any investigation and follow-up actions taken. The OA has established criteria regarding when the CCU must conduct a review, when an on-site visit must occur, and when the change of status assessment must occur.

The CCU is responsible to ensure the health and welfare of the customer and may authorize additional services, such as

intensive care coordination, to protect the welfare of the customer. Critical incidents may also result in a review of customer needs to determine whether a change in the service or level of service is needed.

Other Critical Incidents – Deaths or Injury not related to ANE
For instances of alleged provider or CCU action/inaction leading to reported death or injury (but not due to suspected abuse or neglect), a verbal report must be submitted within twenty-four (24) hours to the Department, Division of Home and Community Services, Office of Community Care Services. The Provider or CCU must immediately follow-up on any such allegation and provide a written report to the Division of Home and Community Services, within five (5) workdays of the incident. When a participant death or injury resulting in the need for medical care occurs during the provision of CCP services, the Provider must notify the CCU and the Division of Home and Community Services within 5 workdays of the incident. Upon notification from the Provider of an incident, the CCU must complete follow-up phone calls to the participant/authorized representative. The CCU must document these follow-up contacts and submit documentation to the Division of Home and Community Services within 10 workdays of the incident.
Upon receipt of injury and/or death reports from the Provider and CCU, Division of Home and Community Services staff will maintain follow-up communication with both agencies if pertinent activity either exists or is required.

MCOs must comply with Critical Incident reporting requirements found in the Elderly Waiver for incidents and events that do not rise to the level of abuse, neglect, self-neglect, or exploitation. The MCOs have similar processes and procedures in place to receive reports, to monitor, and to track and resolve Critical Incidents. Critical events and incidents must be reported and identified issues routed to the appropriate department within the MCO and when indicated to the investigating authority described above. The procedures include processes for ensuring customer safety while the State authority conducts its investigation.

MCOs maintain an internal reporting system for tracking the reporting and responding to Critical Incidents, and for analyzing the event to determine whether individual or systemic changes are needed. MCOs must comply with decision made by the investigating authority.

The customer who is the subject of a report to Adult Protective Services (APS) or customer's family member, or legal representative is informed about the results of the investigation within 60 days of the date the report is received. When the Adult Protective Services authority provides the MCO with a complete report of substantiation decision The MCO has two different requirements regarding contacting the customer. These requirements are directly linked to the outcome of the APS investigation. The first is a 20-day requirement implemented when APS substantiates a report and the customer consents to APS services. The other is a 5-day requirement implemented when the customer refuses the APS investigation at the start or refuses to continue with APS after substantiation.

All substantiation decisions are communicated verbally to the customer during a face-to-face visit. Regardless of substantiation decision the APS supervisor meets with the APS caseworker to discuss and then signs-off on the decision. All APS records are subject to the confidentiality of the APS Act or another act that has stronger requirements.

Notification is documented in the customer’s case record. The APS Program supervisor signs off on the record entry. Compliance with this requirement is reviewed annually as a measurement of case quality. When a case is not substantiated, the customer or (customer’s family member, or legal representative) is informed by the method most appropriate to assure the customer’s confidentiality. For cases that are substantiated, the same confidentiality considerations are applied, but notice of the investigation results is most generally incorporated in the face-to-face visit with the customer when a substantiated risk assessment is completed and a case plan is discussed with the customer that focuses on interventions to mitigate risk.

The APS Report of Substantiation Process policy requires the Adult Protective Services Provider Agency (APSPA) to directly notify the Care Coordination Unit or the MCO of all substantiation decisions within two business days from the date of substantiation. Additionally, the APSPA is required to notify the MCO of the report of the substantiation decision via email within two business days from the date of substantiation.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The OA oversees the reporting and response of all critical incidents and complaints. The OA's uses the CERA system to analyze trends and to ensure that follow up has occurred. For some individual circumstances, the OA may be working with ANE or the CCU to resolve the issue. The OA's Office of Adult Protective Services maintains a tracking system of ANE investigations and statistical reports are generated annually.

Data is used to inform the OA and MA to monitor system performance and remediate problems. CCUs and Care Coordinators receive information in their quarterly performance reports about critical events involving waiver customers for whom they are responsible. The OA and the CCUs also review statewide and regional performance at quarterly meetings.

For customers enrolled in an MCO, the MCOs maintain an internal reporting system for tracking reports and responses to critical incidents. This system is used for analysis of events to determine whether individual or systemic changes are needed. Critical incident reporting is included in the reporting requirements to the MA. The MA monitors both compliance of performance measures and timeliness of remediation for those waiver customers enrolled in an MCO. Customers in MCOs are included in the representative sampling.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The OA and MCOs are responsible for detecting the unauthorized use of restraint.

OA oversight includes:

1. CCU and Care Coordinator reviews of all Event Reports involving the unauthorized use of restraint.

2. IDoA will review instances of the unauthorized use of restraint reported through event reports that are outside the restraint and seclusion policy.

3. During Quality Improvement reviews, IDoA will review substantiated instances of the unauthorized use restraint.

For customers enrolled in an MCO, the Plans are responsible to detect the unauthorized use of restraint. Events involving the use of unauthorized use of restraint are reported to the Plan as a reportable incident, and reported to the investigating authority as indicated.

The MCOs and OA are to detect unauthorized use of restraints through face-to-face visits, routine contacts with the participants, and through complaint or incident reporting. The case coordinators are responsible for the overseeing the waiver participants and assuring their health, safety, and welfare.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The OA and MCOs are responsible for detecting the unauthorized use of restrictive interventions.

OA oversight includes:

1. CCU and Care Coordinator reviews of all Event Reports involving the unauthorized use of restrictive interventions.

2. IDoA will review instances of the unauthorized use of restrictive interventions reported through event reports that are outside the restraint and seclusion policy.

3. During Quality Improvement reviews, IDoA will review substantiated instances of the unauthorized use restrictive interventions.

For participants enrolled in an MCO, the Plans are responsible to detect the unauthorized use of restrictive interventions. Events involving the use of unauthorized use of restrictive interventions are reported to the Plan as a reportable incident, and reported to the investigating authority as indicated.

The MCOs and OA are to detect unauthorized use of restrictive interventions through face-to-face visits, routine contacts with the participants, and through complaint or incident reporting. The case coordinators are responsible for the overseeing the waiver participants and assuring their health, safety, and welfare.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The OA and MCOs are responsible for detecting the unauthorized use of seclusion.

OA oversight includes:

1. CCU and Care Coordinator reviews of all Event Reports involving the unauthorized use of seclusion.

2. IDoA will review instances of the unauthorized use of seclusion reported through event reports that are outside the restraint and seclusion policy.

3. During Quality Improvement reviews, IDoA will review substantiated instances of the unauthorized use seclusion.

For participants enrolled in an MCO, the Plans are responsible to detect the unauthorized use of seclusion. Events involving the use of unauthorized use of seclusion are reported to the Plan as a reportable incident, and reported to the investigating authority as indicated.

The MCOs and OA are to detect unauthorized use of seclusion through face-to-face visits, routine contacts with the participants, and through complaint or incident reporting. The case coordinators are responsible for the overseeing the waiver participants 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: # and % of records reviewed 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 reviewed where the customer/representative received info from the OA/MCO about how and to whom to report unexplained deaths and A/N/E at the time of each assessment.D: Total # of records reviewed.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G2: Number and percent of unexplained deaths and substantiated incidents of A/N/E reported to the OA and MCO where appropriate actions were taken to address incident. N: Number of unexplained deaths and substantiated incidents of A/N/E reported to the OA and MCO where appropriate actions were taken to address incident.D: Number of unexplained deaths and substantiated cases of A/N/E.

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

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

data collection/generation *(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:

Performance Measure:
G3: Number and percent of deaths related to a substantiated case of abuse or neglect that were reported to the OA and MCO where appropriate actions were taken to address incident. N: Number of deaths related to a substantiated case of abuse or neglect that were reported to the OA and MCO where appropriate actions were taken to address incident. D: Number of substantiated cases resulting in death.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and 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 demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:

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

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

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

Data Aggregation and Analysis:

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

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:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
G5: Number and percent of APS substantiated incidents of confinement (restraint or seclusion [R&S]) reported to the OA and MCO where appropriate actions were taken to address the incident. N: Number of substantiated incidents of confinement (R/S) reported to the OA and MCO where appropriate actions were taken to address the incident. D: Number of substantiated incidents of confinement.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports, OA Reports, APS 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**	☐ **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:
G6: Number and percent of in-home service (IHS) (homemakers) and ADS staff who received training on alternative practices to restrictive interventions, including restraint and seclusion (R&S). N: Number of IHS (homemakers) and ADS staff who received training on alternative practices to restrictive interventions, including R&S. D: Total number of IHS (homemakers) and ADS staff reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On site provider reviews or desk audit provider reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Once every 3 year contract period
	☐ **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 reports: Satisfaction survey, MCO reports: 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**

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

Performance Measure:
G8: Number and percent of customers reporting that they visited a doctor or practitioner for an annual screening within the last 12 months. N: Number of customers reporting that they visited a doctor or practitioner for an annual screening within the last 12 months. D: Total number of customer records reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

The OA has a three-prong approach to address health, safety and welfare issues.

First, the state obtains a direct report of potential issues affecting health and safety from the customers. The Care Coordinator completes an initial and annual assessment to determine needs of the customer and uses this information to develop a person-centered plan (PCP). This process includes using the DON to identify unmet needs and the assessment to identify customer satisfaction. Some questions on the comprehensive assessment pertain to the customer's perceptions of safety, privacy, and respectful treatment. The Care Coordinator addresses problems identified during the assessment process either as a service planning issue or a CCP event report. The OA tracks information from the assessment and event reports through its eCCPIS and CCP Event Report systems. Care Coordinators are required to follow-up with any customers reporting that they did not feel safe, that their privacy is not respected, or they are not treated with respect. Care Coordinators' supervisors monitor the Care Coordinators performance in these areas. The OA also monitors the performance of the CCUs.

Second, the OA's approach screens-out potential workers with criminal backgrounds who seek employment with providers. Provider staff, in addition to meeting educational and training requirements for a job, must undergo a background check as part of the conditions of employment. Providers are responsible to complete the background check, maintain information in the employee file, and enter verification in the training tracking database. The MA audits for compliance with this requirement when completing quarterly management reports, during the provider audit, and the documentation is verified during the onsite reviews.

Finally, the approach maintains a system to intervene and remediate reported incidents and complaints. The MA maintains an Event Report system to deal with critical incidents or complaints involving waiver customers. A critical incident includes a range of defined events that negatively impact the health and welfare of a waiver customer. These events are classified within one of four levels of intensity, depending on the nature of the incident and the level of risk posed. A complaint includes any oral or written communication by the customer or other interested party expressing dissatisfaction with the operation or provision of service, service quality, service staff, or a failure to provide/offer services.

Any person can report a critical incident or make a complaint by contacting the state's Senior Helpline, a CCU, or a provider. The state uses an Event system to record information. The Senior Helpline can enter data. After an Event is reported, the CCU receives notice and is responsible to review each incident or complaint. If the report includes suspected abuse, neglect, or exploitation, the state's Adult Protective Service (APS) agency is immediately notified so that it may begin its investigation as required by Illinois Elder Rights regulations.

The state has developed a protocol to deal with reports of critical incidents and complaints. The protocol defines timelines, notification requirements, referrals, and follow up steps. All critical incidents and complaints must be resolved within State set timelines, unless there are documented circumstances that preclude a resolution within this timeline. If resolution is not immediately forthcoming, the CCU is responsible to continue to ensure the health and welfare of the individual during this time.

The MA conducts 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 pulls 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 are summarized by the Plans and reported at least quarterly to the MA.

For the OA, reviews include compliance with employee background checks. Prior to and during onsite provider reviews, the MA reviews related critical event reports.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in the MA's contracts with 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 Operating Agency (OA)/Managed Care Organization (MCO) will assure that customers know how to report 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 all outstanding Adult Protective Service (APS) referrals of substantiated incidents. Changes in customer's 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, that may include training, a plan of correction, or other remediation to assure that critical incidents are being analyzed to determine root cause. Remediation will occur within 30 days.

G5: The OA/MCO will follow up all outstanding APS referrals of substantiated incidents of confinement. Changes in customer's PCP, corrective action plans or provider sanctions will be made when needed. Remediation must be completed within 30 days.

G6: The OA will follow up to ensure training is provided on alternative practices to restrictive interventions, including restraints and seclusion, within 30 days.

G7: If identifying information is available for customer surveys the OA and the MCO Care Coordinator will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Patterns of negative responses, including anonymous survey responses, will be used to identify need for system improvement.

G8: During the initial evaluation or redetermination, the OA or the MCO Care Coordinator will ask whether customer has a primary care doctor or practitioner and whether they had a physical in the last 12 months. If not, barriers will be identified and addressed. Remediation will occur at the meeting between the customer and OA or the MCO Care Coordinator.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

The Medicaid Agency (MA), the Operating Agency (OA) and the Managed Care Organizations (MCOs) work in partnership to evaluate the waiver Quality Management System (QMS). This partnership provides analysis to information derived from discovery and collaboratively develops and monitors remediation activities for each of the federal assurances.

The OA and MA share management reports that track changes in compliance levels for performance measures over time. This includes tracking changes across the entire state as well as by region and provider type. This helps to identify problematic areas and potential best practices. Together, the MA and OA aggregate information and generate reports on a quarterly basis.

The OA takes a multi-phased and multilevel approach to using management reports to improve the overall system. Because changes in the compliance level for a performance measure may be explained by an external factor that would not require remediation (e.g., better targeting of customers with greater impairment than may have an adverse impact on some of the performance measures), the first step is to investigate to try to determine if an actual problem exists. The second step is to formulate potential interventions that may remediate the problem. The third step is to roll out those interventions, possibly on a pilot basis. The final step is to track changes using the original performance measures to assess the impact of intervention.

The state's quality oversight system between the MA and the OA is hierarchical. With regards to waiver management, the process described above is multilevel. The MA oversees the OA, which oversees the individual CCUs, which in turn, oversee the individual Care Coordinators. Consequently, the state's quality management system includes regular and structured oversight meetings to facilitate communication, investigation, and problem solving across the many levels. Each CCU is required to have at least monthly quality management meetings with their individual Care Coordinators. The OA meets with all CCUs on a quarterly basis, and meetings with individual CCUs take place at least annually, and more often if required due to performance issues. The OA and MA meet quarterly.

The OA and MCO’s are responsible for the majority of the data collection to address the Quality Management System discovery and remediation activities. The OA is primarily responsible for eligibility and authorizing qualified providers. Therefore, there are distinct performance measures for these functions under the OA. Additionally, as a result of enhancements in the MA’s data systems, the MA now includes qualified provider performance measures. The MA is specifically accountable for the measures in the Administrative Authority appendix. The Administrative Authority appendix include performance measures for both the OA and the MCOs. Both the OA and the MCOs are accountable for all other measures. 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.

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 is reported as indicated by the performance measure in the waiver. All reports will be provided to the MA for review prior to the quarterly meetings. Annual reports are produced identifying trends based on the representative sample and/or 100% review of data.

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 identify trends based on scope, severity, changes and patterns of compliance by reviewing both the levels of compliance with the performance measures and remediation activities conducted by the OA and the MCOs. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Systems improvement is prioritized based on the overall impact to the customers and the program. Systems improvements may be prioritized based on factors such as: the impact on the health and welfare of waiver customers, legislative considerations, and fiscal considerations. The OA and the MCOs maintains separate QMC Systems Improvement Logs. Recommendations for system improvements are added to the log(s) for tracking purposes. The OA and the MCOs documents the systems improvement implementation activities on its respective log. The MA assures that the recommendations are followed through to completion. Decisions and timelines for system improvement are based on consensus of priority and specific steps needed to accomplish change. These decisions are documented on the systems

improvement log and communicated through the sharing of the quarterly meeting summary and the systems improvement log. HFS hosts weekly operational meetings. All MCOs are required to attend.

The OA shares the following data points with the Care Coordination Units monthly: compliance with annual redeterminations and compliance with critical incident follow up reports. The data is aggregated by contract number. Every quarter, the OA shares the results of the Quality Assurance Survey. Every 6 months, the OA shares the DON Utilization summarized by contract number. Every year, the OA shares the results of the Quality Assurance Survey with each of the provider groups. All of these are shared with the Care Coordination Units. Additionally, the OA shares the results of the annual Quality Assurance Survey with the OAs Advisory groups and specific provider groups that the survey pertains to, e.g. in-home providers. All the data that is shared with the provider network is also shared with the MA at the Waiver quarterly meetings.

ii. System Improvement Activities

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

b. System Design Changes

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

For the OA, the state uses the same mechanisms that it uses to identify potential issues including contract compliance, customer satisfaction, assurances, and critical incident analysis to monitor the effectiveness of all interventions. The state tracks changes in the performance measures using data analysis and reports.

For both the OA and MCOs, customer input also plays a central role in the QMS as follows: 1) Customers' perception of the quality of their services using constructs that are meaningful to customers (e.g., integration in the community, dignity, respect, etc.) as gathered through customer satisfaction tools and the Comprehensive Care Coordination assessment tool. These tools provide the OA and the MCOs with the direct feedback loop about the effect of potential interventions on the quality of life for individual customers; and 2) Care Coordinators share reports with customers and their representatives about how their experience compares to that of other customers across the state.

As an example, the OA, the MCOs and the MA monitor trends in customers' reports of opportunities for community integration using data gathered to assess customer satisfaction. The entities may notice a pattern of low scores for certain providers, but high scores for others. This will lead the OA to query the individual Care Coordinators about provider practices that may explain this discrepancy. The entities will subsequently use best practices that are identified as a core component of training, in the training of poor performers. The OA may even collaborate and utilize providers who appear to be performing well on this training. The OA subsequently tracks the performance of providers who receive this training to assess the efficacy of the intervention.

In the OA waiver quality plan, the State has implemented additional efforts to address its ability to improve and maintain quality. These include:
1) Updated performance measures in each of the waiver areas,
2) Redesigned reports to be used on a quarterly basis,
3) Updated Event Report system and clearer delineation of critical incident definitions and follow-up procedures including training for CCUs on reporting and management of critical events.
4) Implementation of training tracking system and a new case note system, and
5) Implementation of the OA Quality Assurance survey process which has been tested for validity and reliability.

The OA meets with the Community Care Program Advisory Committee (CCPAC) six times a year to present information about the waiver and receive input from providers, stakeholders, and customer representatives. The CCPAC has several work groups, including a quality committee. This process of inclusion of stakeholders has been most effective and is viewed by the OA as a critical element in its QMS. Meeting dates and times are shared with the MA for their information and participation.

The processes Illinois follows to continuously evaluate the effectiveness of the QMS are the same 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, and service providers. Multiple years of data collection will allow the State to evaluate the effectiveness of system improvements over time.

System design changes may be specific to the OA, the MCOs, or both. The purpose of meeting with all parties annually is to provide an arena to see the system holistically, determine how well the system design changes are working, and identify areas that require further improvement. Decisions that are made as a result of these meetings are tracked on the QMC Systems Improvement Log.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

During the quarterly meetings with the OA, the OA and MA review waiver reports and the Quality Improvement Strategies. The OA and the MA, as partners discuss updates that both Departments need to address in the future. The OA also seeks input from its advisory groups on improvements and/or changes to the Quality Improvement Strategy. The OA continually addresses issues as they arise, responds, and implements strategies to improve compliance with performance indicators. The whole QMS is viewed as a continuous ongoing process.

One QMC meeting a year is dedicated as a combined meeting with the MA, the OA, and the MCOs. At this meeting, the entities meet and discuss statewide issues impacting the waiver. During this annual meeting, the OA and the MCOs has on the agenda an overview of the previous year's activities and a discussion of whether changes are needed to the Quality Management Strategy. The MA and the OA see five primary focus areas: These areas are described below.
1) Structure of the QMC: The group reviews the structure of the QMC to determine if it is effective.
2) Trend Analysis: The group evaluates the processes for identifying trends, patterns, and root causes to assure that issues are being identified and analyzed.
3) Systems Improvement Log: The group reviews the QMC Systems Improvement Log to assure that all recommendations have been implemented in accordance with agreed upon timelines, and if not, whether there is justification.
4) System Improvement Priorities: The methods for determining system improvement priorities are evaluated to determine effectiveness.
5) Performance Measures: The entities determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures are reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

The state continuously strives to increase the compliance rate of each performance measure. While the target compliance rate for each performance measure is 100%, the state realizes that it may take multiple system changes over several years to reach the goal of 100% compliance, as well as, all entities involve experience staff changes that require ongoing training.

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

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

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

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

The OA administers the annual quality assurance (QA) survey. The QA surveys go to a representative sample of customers receiving waiver services. The QA survey is specific to Care Coordination and each of the 4 core waiver services (adult day services, in-home (homemaker) services, emergency home response services and automated medication dispenser services. The OA follows up with customers directly in response to feedback or note of concerns. Survey results are analyzed, shared and discussed with waiver service providers for the purpose of ensuring customer satisfaction.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for*

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

(a) Requirements concerning the independent audit of provider agencies;

Independent audits of in-home service (homemaker) provider agencies are required by rule 240.1525(b)(1)-(2). The audits must be conducted annually by an independent Certified Public Accountant and submitted to the OA for review. Staff in the Bureau of Business Services review the audits and ensure each agency required to complete an audit have done so. Any deficiencies or lack of submitted audit(s) are reported to the Office of Community Care Services who initiate corrective and/or contract action on the provider agency until such time as the deficiency is corrected.

All Community Care Program providers are required to submit an annual audit pursuant to 20 ILCS 4.02 m.

(b) The financial audit program that the State conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits;

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

The OA also has mechanisms in place to ensure that provider agency and CCU billings are coded and reimbursed accurately. The process begins after the Level of Care (LOC) determination is completed. The CCU enters information collected from the assessment into CMIS, a relational computerized database. Numerous edits are performed in CMIS that will not allow a CCU to approve a customer to receive services without eligibility criteria being complete and accurate. CMIS will not allow the CCU to process information when the customer's date of birth indicates the customer is under 60 years of age, and thus not eligible for services through the waiver. A customer cannot be authorized to receive services if the customer has not scored the minimum Level of Care on the DON. Additionally, the CCU cannot authorize more services than allowed by the service maximum related to the DON score. The data collected in CMIS creates a Case Authorization Transaction (CAT) that is transmitted to the OA by the CCU.

Once the CAT is sent to the OA, further edits of the data are performed. CATs can be rejected by the OA's computer system for a multitude of reasons. The contract numbers for both the CCU and any provider agency authorized are checked against the MA's file of contract information. If any of the contract numbers are incorrect or not valid for the time period, the CAT will be rejected. The system notifies the CCUs of the rejected CAT and the reason for the rejection so they can correct the information on the CAT and resubmit the CAT with corrected information. The OA's Information Technology and Business Services staff review and update the contract number tables frequently to assure the information is correct in the OA's system.

Edits are also performed based on the type of CAT assessment the CCU has generated. For example, certain information is required for data when the individual has been approved for CCP services which is different than a CAT generated when a customer is denied CCP services. This ensures that all information required to pay a provider is accurate and complete. If a customer is eligible for CCP services the CCU authorizes the provider contract(s) the customer has chosen and authorized the agreed upon units of service for each provider on the CAT transmitted to the OA.

Other edits that ensure appropriate billing is submitted by the provider agency include that the CCU cannot authorize services prior to the application date, prior to the date the CCU determined the customer eligible for CCP, or prior to the initial service date of which the provider agency informs the CCU.

Once the CAT has been accepted in the MA's system for a customer, only the provider agency on the CAT will be authorized to bill beginning after the initial service date. Extensive edits are also conducted at the time of the provider agency's billing. An agency cannot bill for any services that were not authorized by the CCU on the CAT. For example, an ADS cannot bill for transportation if it was not authorized on the CAT; nor can the ADS bill for transportation in a month in which ADS services were not provided.

Provider agencies submit billing to the OA by either uploading a file from their local computer or entering the data directly on the eCCPIS Internet web pages. If uploading a file from the computer, billing claims will reject for several reasons including: if the customer information is not in the OA's system, the provider contract number is not accurate or current, or for an invalid provider service code. The system notifies the providers of these rejected billings so they can correct their errors are resubmit their bills.

Another safeguard for all provider billings is that the payment will be rejected if the billing was previously submitted. Once a CCU bills for a particular assessment, that assessment will no longer appear as viable to be billed. Provider agencies cannot bill over the authorized number of units for a month of service. Additionally, if one provider agency has already

billed for a given month and the customer has switched providers during that month, and the second provider agency attempts to bill for service that exceeds their portion of the month, the eCCPIS will verify that the second provider agency is authorized, and will also reject the billing if that agency bills more than is allowable based on the DON score and the billing by the first agency.

The MA has implemented oversight procedures that provide increased 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 waiver for Persons who are Elderly 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 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. Claims for waiver services are compared with claims for nursing home, hospitalized, or death dates to look for overlapping dates of service to ensure there is no fraudulent or inappropriate billings. Agency staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year the MA conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. 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. In addition to the exception reviews of waiver claims, MA staff conduct targeted reviews of individual waiver services, utilization of waiver services by individual customers and billing trends and patterns of providers. These reviews are usually conducted on an impromptu basis.

The results of all financial reviews are presented to OA personnel under cover memos with supporting claim detail. The OA advises the MA of corrective actions taken, including adjustments, for all service claims identified by the reviews that were not paid in accordance with defined parameters.

In addition to the MA post-review and the OA edits described above, the OA also has staff review Hours of Service Calendars (HOSCs) for a sample of customers during Quality Improvement reviews of ADS and homemaker provider agencies. HOSCs are checked for accuracy of completion including signatures of the customer, worker, and supervisor and accurate total number of units. OA staff also compare the number of units on the HOSC to the number of units billed by the provider agency for that month.

The OA continuously implements enhancements to the eCCPIS in order to assist CCUs and provider agencies with billing processes. The OA seeks input from provider agencies, CCU users of eCCPIS and Area Agency on Aging staff on functional improvements to the system. Several reports have been added to the eCCPIS as a result.

The OA contracts with Shawnee Information Systems Development (SISD) to maintain and update CMIS and provide technical assistance to all CCU users. SISD conducts periodic trainings for CCU users on how to enter data and utilize reports available in CMIS.

c) The agencies responsible for conducting the financial audit program:

The MA and OA are responsible for conducting the financial audit program.

For customers enrolled in an MCO, the MA's internal and external auditing procedures will ensure that payments are made to an MCO 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 as part of the HealthChoice Illinois/MMAI. The MCO must have an internal process to validate payments to waiver providers. This includes the claims processing system verifying a customer's waiver eligibility prior to paying claims.

Regarding avoidance of customer coercion, customer choice is a requirement of the CCP Administrative Rule 240.330. Upon assessment, Care Coordinators discuss service options. Once a customer chooses to receive CCP services, he or she is given a choice of provider agency(ies). Care Coordinators are trained to educate customers and provide an informed choice on the available providers. The OA utilizes a Participant Consent Form, which the customer signs, to document customer choice of providers.

The State has several measures in place to ensure that claims describe services rendered. First, errors in billing may be found by the Care Coordination Unit or waiver provider. Second, the MA's claiming system does not allow the OA to

submit a claim for a period in which the customer was not active on Medicaid or was active on another HCBS waiver.

Further, the OA has implemented systematic checks in the billing and case management systems, to combat errors and fraud, which verify customer identification, date of death and MCO eligibility dates. Each entity can review the identified errors and send in a corrective billing through the OA system during the current fiscal year or they must remit a check for errors in prior fiscal years.

Other errors found in billing are identified and provided to the respective providers and Care Coordination Units via the OA recoupment reports on the OA eCCPIS portal.

The OA fiscal division also sends letters to the providers and Care Coordination Units regarding the amount owed and the process for review and submission of payment. The OA submits the corrected billing through the regular electronic feed to the MA.

Additionally, the MA's Office of Inspector General (OIG) has jurisdiction to investigate concerns of waste, fraud, and abuse. The OA and the MA OIG work closely together to refer concerns for each entity to investigate. Finally, to ensure billing submissions match services provided, quality improvement reviews are conducted by the OA for each OA contracted CCP provider at least once during each three-year contract cycle.

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***

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:
I2: Number and percent of payments made for services rendered that were coded and paid in accordance with the reimbursement methodology and specified in the customer's PCP. N: Number of payments for services rendered that were coded and paid in accordance with the reimbursement methodology and specified in the customer's PCP. D: Total number of OA and MCO payments reviewed.

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

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:*

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

For those functions delegated to the 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 through fiscal monitoring and ongoing reporting by the OA and MCO.

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

For the administrative claims review, the MA reviews the entire MA claim related to Medicaid administrative costs.

For the waiver claims review, the MA staff utilize the Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The MA utilizes an exception report and review format as a component of the agency's financial accountability activity. MA staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year the MA conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. This review will include capitation payments made to MCOs and encounter claims submitted by MCOs.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in the MA's contracts with the MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc.

Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver customers enrolled in an MCO through customer surveys and quarterly record reviews. Customers in MCOs are included in the representative sampling.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the 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 customers' waiver enrollment. Remediation must be completed within 30 days. The MA will adjust the federal claim for services provided by the MCO prior to the customers' waiver enrollment. Remediation must be completed within 30 days.

I2: The OA/MCO will determine whether the service was coded and paid correctly. If coded and/or paid incorrectly, the OA/MCO is notified and the federal claim is voided and resubmitted. Remediation must be completed within 30 days.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

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

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

The 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 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 develop the proposed rates and shares the proposed rates and methodology with the MA. The process for establishing and updating payment rates, effective since the initial waiver approval, are described below.

The State will rebase the CCP services within 5 years from the previous rebasing.

In addition to this rebasing process, the rates for each waiver service are reviewed annually to ensure budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. In reviewing fixed unit rates of reimbursement, the State takes into consideration (1) service utilization and cost information, and (2) current market conditions and trend analyses.

Emergency Home Response Service (EHRS):
EHRS is administered by the Illinois Department on Aging (IDOA) Community Care Program (CCP) services as part of the Medicaid Home and Community-Based Services (HCBS) Waiver program authorized in §1915(c) of the Social Security Act. It is a 24-hour emergency communication link to assistance outside the home for older adults with documented health and safety needs and mobility limitations. This service is provided by a two-way voice communication system consisting of a base unit and an activation device worn by the customer that will automatically link the older adult to a professionally staffed support center. EHRS payments consist of a one-time installation fee and a separate monthly rate for ongoing rental and technical support of the EHRS.

The State worked with an external vendor to review its rates to determine if the current rates are efficient, cost effective and allow for the purchase of services at the lowest rate that will ensure access to waiver services by multiple providers.

Based upon its analysis, the State increased the Medicaid reimbursement rate for EHRS to $40 for a one-time installation. In developing the rate, the State examined Medicaid reimbursement rates paid in other states, as well as analyzed installation costs incurred by existing contracted and non-contracted providers. The State examined the cost components underlying into the installation activity, which could include administrative costs (completing paperwork, contacting the customer, scheduling an appointment), training and testing (include training the customer to properly use the device and testing the range capacity within the device) and the cost of transportation to the customer's home to perform the installation. Based on this analysis, the State will employ a methodology of frequent, ongoing review to ensure that the installation rate remains in line with similarly situated programs in other states and is reflective of the cost of providing the installation service.
The current rate for monthly EHRS service is $28.00 per month.
The current rate for one-time EHRS Installation is $40.00.

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

The State worked with an external vendor to review its rates to determine if the current rates are efficient, cost effective and allow for the purchase of services at the lowest rate that will ensure access to waiver services by multiple providers.

Currently, the ADS rate is based on a fee-for-service structure. Providers are paid on an hourly basis for ADS services. The ADS Transportation rate is a separate fixed fee rate calculated independently of the ADS rate. Providers are paid

per one-way trip for ADS Transportation. These rates were originally established by legislation. A study of day service rates was last conducted in 2018, and rates were last increased in 2019.

The State used multiple means to obtain necessary data to complete a thorough rate analysis for the ADS program and ADS Transportation. This process included conducting focus groups which included customers, stakeholders, reviewing existing state data, and developing and distributing two provider surveys.

Ultimately, the rate increase recommended by the state will better accommodate program standards (particularly, staffing ratios) and all the other significant rate inputs.

The current rate for Adult Day Service is $14.30 an hour/unit.
The current rate for Adult Day Service Transportation is $10.29 per one-way trip.

In-Home Service (Homemaker):
In-Home services (homemakers) are general non-medical supports provided by supervised homecare aides who receive specialized training in the provision of in-home (homemaker) services. The services provided through this program include:
• Teaching/performing of meal planning and preparation
• Routine housekeeping
• Shopping skills/tasks
• Home maintenance and minor repairs
• Assisting with self-administrated medication
• Assisting with shopping, errands, personal care tasks
• Escorting customers to medical facilities or individual business

These services are provided to customers based on their person-centered plan (PCP) of care with the goal of maintaining, strengthening, and safeguarding the functioning of the customers in their own home.

In-Home service (homemaker) providers must not only ensure that these services are available, but also meet the requirements specified in the federal HCBS Final Rule. The expectations of the Final Rule include the full implementation of the person-centered planning practices that have been in place in the federal HCBS rules previously. The Final Rule added the new and more explicit requirements for: Choice of Services; Individual Rights; Autonomy and Independence; Community Integration; Privacy, Self-determination; Physical Accessibility; Visitors; Landlord Tenant Rights; and Transportation. The Final Rule determines how a person experiences the HCBS setting(s) and if the services (both paid and unpaid) support them to have a life that is fully integrated into the community as specified in their PCP.

Currently, the in-Home service (homemaker) rate is based on a fee-for-service structure. Providers are paid on a fixed unit rate of $23.40 per hour of service. This rate is designed to include both administrative and direct service costs. The rates are not geographically based and do not include room and board. The in-Home service (homemaker) rates were originally established by requesting information from customers on their costs for providing the service and the size of the population each customer projected it could serve.

In response to legislation passed by the Illinois General Assembly (GA) in 2020, the in-home service (homemaker) rate increased from $21.84 to $23.40 effective 4/1/2021. This rate follows the rate methodology as approved in the waiver. In accordance with the rate study completed by the Department in 2019, IDOA has continued to monitor and collect information from in-home providers through the Direct Service Worker Cost Certification worksheet to understand the adequacy of the rate. This rate increase supports providers efforts to retain staff, address the demands of a competitive job market, maintain service requirements, and ensures providers are properly reimbursed for operating costs.

The current rate for In-Home Service (homemaker) is $23.40 an hour/unit.

Amendment IL.0143.R07.02, effective 1/1/2023, increased the homemaker rate to $25.66 an hour/unit.

Amendment IL.0143.R07.03, effective 03/01/2023, or upon CMS approval, increases the homemaker rate from rom $25.66 to $26.92 an hour/unit.

Automated Medication Dispenser (AMD):

AMD payments consist of a one-time installation fee and a separate monthly rate for ongoing rental and technical support of the AMD. The installation rate covers maintaining adequate local staffing levels of qualified personnel to service necessary administrative activities, installation, and in-home training. The monthly rental rate covers maintaining administrative and technical support to program machines, providing 24 hour technical assistance, signal monitoring, troubleshooting, providing machine maintenance and repair requests in a timely manner, sending notifications on missed doses, and providing reports as requested by IDoA.

The AMD fixed unit rates were established in 2013, pursuant to an Request For Information (RFI) process that allowed for the calculation and subsequent establishment of a fixed rate and research on other states' approaches to obtaining Medicaid reimbursement for the provision of AMD services. IDoA sent RFI questions to all of the providers that were contracted with IDoA for EHRS. Four vendors with 7 different units responded to IDoA's RFI with information on rates and unit specifications. The average quotes for installation and monthly monitoring from all providers were $45.00 and $38.16, and the median quotes were $50.00 and $36.00. However, for the two providers who met IDoA's service specifications, the quoted rates for installation and monitoring were $50 and $40, and $60 and $60. Based on this information, IDoA chose, and HFS approved, rates of $50 for installation and $40 for monitoring. Those figures were at or near the average and were the lowest of the rates provided by the vendors that met minimum requirements.

Although IDoA's research into other states' rates for the same service revealed several states with service or payment methodologies too distinct to allow comparison, IDoA concluded that these rates were comparable to those quoted to Wisconsin. In response to that state's RFI, three vendors quoted monthly AMD rates of $57.00, $44.95, and $26.95.

Rates are not geographically based and do not include room and board.

The current rate for AMD one-time installation is $50.00.

The current rate for AMD monthly service is $40.00 per month.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Fee-for-Service Providers are paid by the OA. Bills submitted by the provider are generated through the OA eCCPIS billing system. The OA will not accept a bill for payment unless that service has been authorized in the case management system and verified by the eCCPIS rules engine. eCCPIS provides authorized services and service cost maximums for the customer as per the determination of need/assessment. Billings are rejected if the customer is enrolled in an MCO and the provider will be directed to submit the bill to the appropriate MCO for reimbursement. Billings will also be rejected if the customer is identified on the State's Public Health death record as deceased on the date of service.

Valid billing submissions are submitted to the MA on a weekly basis, to determine Medicaid eligibility. The MA then returns a weekly file to the OA with an OBRA indicator code for all those customers who met the eligibility criteria. Customers who were not returned with an OBRA indicator code are researched by the OA staff and re-submitted. If issues are corrected, the MA will provide the OA OBRA indicator code. If the customer is enrolled in Medicaid and meets the qualifications, the customer will be enrolled in an MCO. All billings that were accepted by the MA from OA with the OBRA indicator code are eligible for federal financial participation. Federal financial claiming is submitted by MA.

To ensure billing match services provided, Quality Improvement reviews are conducted by the OA for each contracted CCP provider at least once during a contract cycle (3 years). The review is performed by OA staff as an independent desk review. This ongoing administrative activity allows the OA to ensure that providers and CCUs are adhering to the rules, regulations, policies, and procedures of CCP.

CCP service claims are reviewed by the OA. The OA chooses a random stratified sample from their eCCPIS billing records. The sample includes both waiver customers and non-waiver customers covered by General Revenue funding. If the OA is aware of a particular customer's concern via the complaint/SIP process or other means, that customer's file is included in the sample. A minimum of 5 customer files are chosen for each contract number reviewed.

Documentation reviewed includes, but is not limited to, date of initiation of service, complaint follow-up, reporting concerns to the CCU, etc. Verification is also thoroughly reviewed that billing submitted to the OA by the provider matches what the customer acknowledged for provision of service, including dates, and in/out times by the homecare aide. In-home service (homemaker) providers are required to utilize Electronic Visit Verification (EVV) to electronically track and document time spent by the homecare aide in the customer's residence. Personal care services are subject to EVV. 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.

Any billing errors found during the QI review require the provider agency to submit negative billings to correct the error. Monthly capitated rates are paid by the MA to the MCO. This payment is generated by the MMIS based on the customer's eligibility for waiver services as identified in the database. The MCOs only receive payment for customers eligible for waiver services. The MCO payment process is automated to generate a monthly capitation to the MCOs based on the rate cell of each customer each month. The MA reviews to ensure the accurate rate is entered into the system, and spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report any discrepancies to the MA.

In general, the rate cells for the Medicaid Component are stratified by age (21-64 and 65+), geographic service area (Greater Chicago and Central Illinois), and setting-of-care. Capitation Rate updates will take place on January 1st of each calendar year. MCOs will be provided a rate report, to be signed by MA and MCO, on an annual basis for the upcoming calendar year.

The State has a monthly capitation program that reads the State's Recipient Database to determine who is enrolled with a particular MCO. The program includes logic that uses the customer's eligibility criteria to determine the appropriate rate cell to be used in generating the payment. As a result of this process, a file is created of MCO schedules which are then sent on to the Comptroller for payment. Once the payment has been made by the Comptroller, a file is sent back to the MA by the Comptroller that includes a warrant number and date. The MA then creates a HIPAA 820 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 MCO's claims processing system must verify a customer's waiver eligibility prior to paying claims.

The MCO payment process is automated to generate a monthly capitation to the MCO based on the rate cell of each customer, each month. The MA reviews to ensure the accurate rate is entered into the system, and spot checks payment reports to ensure payments are made correctly. In addition the MCOs are required to review their monthly payment and report to the MA for discrepancies. Lastly, the MA performs post-payment financial reviews.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

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

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Provider billings are validated by the MA to verify the effective date of the customer's authorization for services as included in an approved person-centered plan of care. Paid Claims are passed through to the MA and MMIS processing edits are initiated for Medicaid and waiver eligibility. Lastly, the MA performs post-payment plan of care and financial reviews.

Oversight to ensure that appropriate services were provided occurs in a variety of methods. Working with the customer/authorized representative, the Care Coordinator authorizes the appropriate type and amount of services via a signed Customer Agreement. This information is included in the electronic Community Care Program Information System (eCCPIS) through which CCUs and providers submit billings to the OA. The eCCPIS contains several features designed to ensure appropriate billing and services, including: 1) eCCPIS security measures do not allow for unauthorized individuals to submit billings; 2) CCUs and providers cannot submit billings that are not authorized; 3) Providers cannot submit billings over the authorized amount; and 4) customers/authorized representatives validate services provided by providers via signed electronic or paper means.

Monthly capitated rates are paid by the MA to the MCO. This payment is generated by the Medicaid Management Information Systems (MMIS) based on the customer's eligibility for waiver services as identified in the database system. The MCO payment process is automated to generate a monthly capitation to the MCOs based on the rate cell of each customer, each month. The MA reviews to ensure the accurate rate is entered into the system, and also spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report to the MA any discrepancies. Lastly, the MA performs post payment financial reviews.

The MCOs are required to have internal processes to validate payments to waiver providers. The MCO claims processing system must verify a customer's waiver eligibility prior to paying claims. The MCO payment process is automated to generate a monthly capitation to the MCOs based on the rate cell of each customer each month. The State reviews to ensure the accurate rate is entered into the system, and also spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report to the MA for discrepancies.

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 and submits to the comptroller's office for payment. Claims are 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 MCO. This payment is generated by the MMIS based on customer's eligibility for waiver services as identified in the database system. The MCOs receive a specific payment for those eligible for waiver services.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The limited fiscal agent is a function of the OA.

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.

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 OA passes the detail expenditure data once a month via an electronic tape to the MA, the Single Statewide Medicaid claiming agency for the State of Illinois. The data is fed into the Medical Management Information System (MMIS) and is subject to edits to ensure the information provided is accurate and 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 pass into the Management Administrative Reporting System (MARS) reporting unit. The MARS unit is responsible for generating the reports to the Bureau of Federal Finance (BFF) who use the reports to claim Medicaid expenditure data quarterly on the CMS 64. MARS also has a series of edits and codes that are used to filter data to ensure accuracy and to determine to what program the expenditure should be reported. The BFF reports the expenditures on the CMS 64 on a quarterly basis 30 days after the quarter's end.

In accordance with the Cash Management Improvement Act (CMIA), the BFF draws down federal monies from the Title XIX grant for the waiver on a weekly basis and deposits the funds into the General Revenue Fund (GRF). The amount to be drawn is an estimate derived by using historical expenditure data. Once the CMS 64 is completed at the quarter's end, the BFF reconciles the estimated cash draw to the actual expenditures reported on the CMS 64. The reconciling expenditure amount is either added to or subtracted from the grant award depending on whether the adjustment is over or under the original estimated amount.

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Not applicable.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

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

◉ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

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

The only service that will have an enhanced rate is the in-home services (homemaker). This service would be only for in-home service (homemaker) 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 received the enhanced rate would be able to 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 MA 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.

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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 OA receives the non-federal share through the General Revenue Fund appropriations.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as

CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- (●) ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*
- ( ) ***Applicable***

Check each that applies:

- [ ] ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

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

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

Check each that applies:

- [ ] ***Health care-related taxes or fees***
- [ ] ***Provider-related donations***
- [ ] ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ( ) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	9972.92	4474.80	14447.72	45335.76	5217.90	50553.66	36105.94
2	10589.65	4664.88	15254.53	47650.72	5456.15	53106.87	37852.34
3	10839.87	4863.45	15703.32	50084.03	5705.38	55789.41	40086.09
4	10848.70	5070.92	15919.62	52641.75	5966.10	58607.85	42688.23
5	10848.70	5287.69	16136.39	55330.24	6238.85	61569.09	45432.70

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	124498		124498
Year 2	132591		132591
Year 3	141209		141209
Year 4	150389		150389
Year 5	160164		160164

Appendix J: Cost Neutrality Demonstration

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

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

The average length of stay was projected based on actual experience from the current waiver period and projected phase-in and phase-out assumptions. The calculations of the ALOS estimate of 281 for WY 1 in the renewal period is equal to the projected total number of days for members on the waiver during WY 1 divided by the unduplicated participant count (34,940,723/124,498).

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 the 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 was provided by the MA from MMIS. The State adjusted the experience for some missing encounter claims and utilization not reported in the correct unit base. We 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. The State also increased the utilization of automated medication dispenser services and installations because these services were new during the experience period and utilization is expected to increase.

Factor D for the new 5-year waiver period for the renewal (October 1, 2021 through September 30, 2026) was projected from FFY 2019 in the following manner:

Unduplicated users were projected based on total projected slots.

The count of unduplicated users per 1,000 total participants from the adjusted FFY2019 experience was utilized as the basis for projecting unduplicated users by category of service for all waivers. As such, the growth in unique users for each service category between waiver years is a function of the growth of unduplicated users by category of service for each waiver year. For example, the 107,863 for In-home services (homemaker) in waiver year two of the renewal period is equal to 101,280 (# of users from year one) multiplied by the change in unduplicated from WY1 to WY2 (132,591/124,498).

We reviewed enrollment trends in MMIS from October 2017 through December 2020 to estimate total enrollee growth of 4.9% annually through June 2021, consistent with late 2020/early 2021, and 6.5% annual growth beginning in July 2021, consistent with late 2019/early 2020. For phase-out assumptions, we relied on historic trends to estimate that 2.8% 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 2.8% assumption.

Average units per user were projected to vary with average length of stay.

The adjusted FFY 2019 experience was utilized as the basis for projecting average units per user per category of service for WY 1. Amounts for WY2 through WY5 were calculated by multiplying the prior year average units per user by the change in ALOS between waiver years. We project ALOS to be unchanged for each of the five projected waiver years. As a result, average units per user remain unchanged. As an example, the 453 units per user of in-home service (homemaker) in WY 3 of the renewal period is equal to (# of units per user from WY2) multiplied by the change in ALOS from WY2 to WY3 (281/281).

Average cost per unit was maintained across the length of the renewal period based on current fee schedules:

Adult Day Service:
01/01/21: $14.30
04/01/21: $14.30
01/01/22: $15.30

Adult Day Service Transportation:
01/01/21: $10.29
04/01/21: $10.29
01/01/22: $11.29

In-Home Service (homemaker):
01/01/21: $23.17
04/01/21: $24.73
01/01/22: $26.29

Automated Medication Dispenser Service:
01/01/21: $40.00
04/01/21: $40.00
01/01/22: $40.00

Automated Medication Dispenser Installation:
01/01/21: $50.00
04/01/21: $50.00
01/01/22: $50.00

Emergency Home Response Service:
01/01/21: $28.00
04/01/21: $28.00
01/01/22: $28.00

Emergency Home Response Service Installation:
01/01/21: $40.00
04/01/21: $40.00
01/01/22: $40.00

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 the CY 2021 HealthChoice and July MMAI capitation rates for services other than LTC services for Nursing Facility rate cells.

Factor D' was trended at a rate approximately 4.3% per year based on a blend of trend rates utilized in the 2021 capitation rates.

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 illustratred in the CY 2021 HealthChoice and July 2021 MMAI capitation rates for LTC services for Nursing Facility rate cells.

Factor G was trended at a rate of approximately 5.1% per year based on a blend of trend rates utilized in the 2021 capitation rates.

Estimates of Factor G are illustrated in the cost neutrality summary in Appendix J-1 Composite Overview and Demonstration of Cost Neutrality Formula.

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

Base year data reflects projected benefit expenses illustrated in the CY 2021 HealthChoice and July 2021 MMAI capitation rates for non-LTC services for Nursing Facility rate cells.

Factor G' was trended at a rate of approximately 4.6% per base year based on a blend of trend rates utilized in the 2021 capitation rates.

Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary in Appendix J-1 Composite Overview and Demonstration of Cost Neutrality Formula.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Service	
In-Home Service (Homemaker)	
Automated Medication Dispenser (AMD)	
Emergency Home Response Service	

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:							43938001.44
Adult Day Service Transportation	☒	Trip	4832	141.81	11.04	7564894.16	
Adult Day Service	☒	Hour	5232	461.93	15.05	36373107.29	
In-Home Service (Homemaker) Total:							1187671729.25
In-Home Service (Homemaker)	☒	Hour	101280	452.94	25.89	1187671729.25	
Automated Medication Dispenser (AMD) Total:							295972.40
Automated Medication Dispenser Service	☒	Month	1036	6.96	40.00	288422.40	
Automated Medication Dispenser Installation	☒	One-Time	151	1.00	50.00	7550.00	
Emergency Home Response Service Total:							9703226.24

GRAND TOTAL:	1241608929.33
Total: Services included in capitation:	1241608929.33
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	124498
Factor D (Divide total by number of participants):	9972.92
Services included in capitation:	9972.92
Services not included in capitation:	
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Home Response Service	☒	Month	48323	6.96	28.00	9417186.24	
Emergency Home Response Service Install	☒	One-time	7151	1.00	40.00	286040.00	

GRAND TOTAL:	**1241608929.33**
Total: Services included in capitation:	1241608929.33
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**124498**
Factor D (Divide total by number of participants):	**9972.92**
Services included in capitation:	9972.92
Services not included in capitation:	
Average Length of Stay on the Waiver:	281

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:							**47619197.18**
Adult Day Service Transportation	☒	Trip	5146	141.81	11.29	8238925.60	
Adult Day Service	☒	Hour	5572	461.93	15.30	39380271.59	
In-Home Service (Homemaker) Total:							**1345968121.91**
In-Home Service (Homemaker)	☒	Hour	107863	452.94	27.55	1345968121.91	
Automated Medication Dispenser (AMD) Total:							**315403.60**
Automated Medication Dispenser	☒	Month	1104	6.96	40.00	307353.60	

GRAND TOTAL:	**1404092567.81**
Total: Services included in capitation:	1404092567.81
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**132591**
Factor D (Divide total by number of participants):	**10589.65**
Services included in capitation:	10589.65
Services not included in capitation:	
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service							
Automated Medication Dispenser Installation	☒	One-Time	161	1.00	50.00	8050.00	
Emergency Home Response Service Total:							10189845.12
Emergency Home Response Service	☒	Month	51464	6.86	28.00	9885205.12	
Emergency Home Response Service Install	☒	One-time	7616	1.00	40.00	304640.00	

GRAND TOTAL:	1404092567.81
Total: Services included in capitation:	1404092567.81
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	132591
Factor D (Divide total by number of participants):	10589.65
Services included in capitation:	10589.65
Services not included in capitation:	
Average Length of Stay on the Waiver:	281

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:							50712388.34
Adult Day Service Transportation	☒	Trip	5480	141.81	11.29	8773671.25	
Adult Day Service	☒	Hour	5934	461.93	15.30	41938717.09	
In-Home Service (Homemaker) Total:							1469876585.07
In-Home	☒					1469876585.07	

GRAND TOTAL:	1530687193.21
Total: Services included in capitation:	1530687193.21
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	141209
Factor D (Divide total by number of participants):	10839.87
Services included in capitation:	10839.87
Services not included in capitation:	
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service (Homemaker)		Hour	114874	452.94	28.25		
Automated Medication Dispenser (AMD) Total:							**335670.00**
Automated Medication Dispenser Service	☒	Month	1175	6.96	40.00	**327120.00**	
Automated Medication Dispenser Installation	☒	One-Time	171	1.00	50.00	**8550.00**	
Emergency Home Response Service Total:							**9762549.80**
Emergency Home Response Service	☒	Month	54809	6.15	28.00	**9438109.80**	
Emergency Home Response Service Install	☒	One-time	8111	1.00	40.00	**324440.00**	

GRAND TOTAL:	**1530687193.21**
Total: Services included in capitation:	1530687193.21
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**141209**
Factor D (Divide total by number of participants):	**10839.87**
Services included in capitation:	10839.87
Services not included in capitation:	
Average Length of Stay on the Waiver:	281

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:							**54012023.99**
Adult Day	☒					**9345240.71**	

GRAND TOTAL:	**1631524575.96**
Total: Services included in capitation:	1631524575.96
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**150389**
Factor D (Divide total by number of participants):	**10848.70**
Services included in capitation:	10848.70
Services not included in capitation:	
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service Transportation		Trip	5837	141.81	11.29		
Adult Day Service	☒	Hour	6320	461.93	15.30	44666783.28	
In-Home Service (Homemaker) Total:							1565433789.81
In-Home Service (Homemaker)	☒	Hour	122342	452.94	28.25	1565433789.81	
Automated Medication Dispenser (AMD) Total:							357706.80
Automated Medication Dispenser Service	☒	Month	1252	6.96	40.00	348556.80	
Automated Medication Dispenser Installation	☒	One-Time	183	1.00	50.00	9150.00	
Emergency Home Response Service Total:							11721055.36
Emergency Home Response Service	☒	Month	58372	6.96	28.00	11375535.36	
Emergency Home Response Service Install	☒	One-time	8638	1.00	40.00	345520.00	

GRAND TOTAL:	1631524575.96
Total: Services included in capitation:	1631524575.96
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	150389
Factor D (Divide total by number of participants):	10848.70
Services included in capitation:	10848.70
Services not included in capitation:	
Average Length of Stay on the Waiver:	281

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:							**57523570.64**
Adult Day Service Transportation	☒	Trip	6216	141.81	11.29	**9952032.94**	
Adult Day Service	☒	Hour	6731	461.93	15.30	**47571537.70**	
In-Home Service (Homemaker) Total:							**1667184043.17**
In-Home Service (Homemaker)	☒	Hour	130294	452.94	28.25	**1667184043.17**	
Automated Medication Dispenser (AMD) Total:							**380807.20**
Automated Medication Dispenser Service	☒	Month	1333	6.96	40.00	**371107.20**	
Automated Medication Dispenser Installation	☒	One-Time	194	1.00	50.00	**9700.00**	
Emergency Home Response Service Total:							**12482910.08**
Emergency Home Response Service	☒	Month	62166	6.96	28.00	**12114910.08**	
Emergency Home Response Service Install	☒	One-Time	9200	1.00	40.00	**368000.00**	

GRAND TOTAL:	**1737571331.09**
Total: Services included in capitation:	1737571331.09
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**160164**
Factor D (Divide total by number of participants):	**10848.70**
Services included in capitation:	10848.70
Services not included in capitation:	
Average Length of Stay on the Waiver:	281