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 waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

Request for 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:**
Illinois Supportive Living Program

C. **Waiver Number:IL.0326**
Original Base Waiver Number: IL.0326.90

D. **Amendment Number:IL.0326.R03.03**

E. **Proposed Effective Date:** *(mm/dd/yy)*
03/01/14

Approved Effective Date: 03/01/14
Approved Effective Date of Waiver being Amended: 07/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The Illinois Department of Healthcare & Family Services (HFS) is amending the current 1915(c) waivers to include those participants whose waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) and under the 1915(b)Managed Long-term Supports and Services (MLTSS) waiver. The MMAI will operate under Section 1932(a)(1)(A)(ii) of the Social Security Act. The proposed effective date for initial implementation will be March 1, 2014 for the greater Chicago and Central Illinois regions. Beginning March 1, 2014, participants will be able to voluntarily enroll in MMAI. Passive enrollment will begin June 1, 2014.

HFS is submitting a concurrent 1915b/c waiver (1915(b) MLTSS waiver) to mandatorily enroll into managed care the dual population receiving Long-term Supports and Services (LTSS) that opt-out of the MMAI. For those participants who wish to opt-out of the MMAI and are receiving LTSS, HFS will provide LTSS, behavioral health (mental health and substance abuse), and transportation services, using the same Health Plans chosen for MMAI. The difference is that these participants will not have their Medicare covered services covered or coordinated by the Health Plans. For those who opt-out of MMAI and are not receivng LTSS, those participants will receive their Medicaid services via fee-for-service.

Background on the Integrated Medicare Medicaid Alignment Initiative.

On February 22, 2013, HFS received approval from the federal Centers for Medicare and Medicaid Services (CMS) to jointly implement the MMAI. The MMAI is a groundbreaking joint effort to reform the way care is delivered to clients eligible for both Medicare and Medicaid Services (called "dual eligibles"). The MMAI demonstration project will provide coordinated care to more than 135,000 Medicare-Medicaid enrollees in the Chicagoland area, including Cook, DuPage, Kane, Kankakee, Lake and Will counties, as well as throughout central Illinois, including Champaign, Christian, Dewitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell and Vermillion counties. Under

the MMAI, Illinois and CMS will contract with Health Plans to coordinate the delivery of and be accountable for all covered Medicare and Medicaid services for participating Medicare-Medicaid enrollees. This includes HCBS waiver services. Eight Managed Care Organizations (Plans) were chosen by HFS for MMAI. Participants will have the choice of six Plans in the greater Chicago region and two Plans in the Central Illinois region.

Prior to choosing a Plan, HFS will provide a choice to all potential enrollees for the participation in the MMAI demonstration. This program will be operated under IL.13-015, a 1932a State Plan Authority. HFS realizes that not all potential enrollees will choose this program; therefore HFS will have a separate program for those who opt-out and are receiving LTSS (MLTSS waiver). This program will not include Medicare covered services, but will include Medicaid covered long term support services (nursing homes and waiver services) and transportation and behavioral health services. For those who opt-out of the MMAI demonstration and are receiving LTSS, enrollment with a Health Plan will be mandatory in order to receive Medicaid LTSS, transportation and behavioral health services. The Plans will coordinate care for all participants enrolled in MMAI or the 1915(b) MLTSS waiver. The only difference is that for those who opt-out, the Plans will not be responsible for the Medicare-only services.

Waiver and Other Assurances

HFS, as the Medicaid Agency (MA), will continue to meet federal Centers for Medicare and Medicaid Services (CMS) assurances required under the waiver. HCBS waiver eligibility determinations will continue to be conducted by separate entities contracted by the State, just as they are done today. Information specific to the 1915(c) waiver oversight responsibilities follows.

Eligibility
Waiver eligibility determination and redetermination criteria will remain the same as in the existing waiver and will be the same for all waiver participants, including those being served by the Plans.

Case Management
Qualified waiver providers will remain responsible for coordinating and delivering waiver services. Overall health care coordination, including waiver services for participants in the MMAI or the MLTSS waiver, will be the responsibility of the Plans. Plans bring resources to the programs that will more effectively coordinate community based supports and services with physical health and other state plan services to meet the needs of the whole participant enrolled in MMAI or the MLTSS waiver. The Plans have the staffing and information technology resources to connect and share information from the many providers that serve participants. These resources will enhance oversight and monitoring of the provision of services and assure that needs are being met.

Service Delivery - Provider Qualifications
The same approved waiver services are available through the Plans. Service delivery will remain the responsibility of the qualified providers. Plans will recruit providers, and in the first year of the MMAI and MLTSS waiver, are required to contract with any willing and qualified providers currently approved to provide waiver services. Methods for determining provider qualifications for waiver services remain the same as described in the existing waiver. The Plans will be responsible to ensure that providers are qualified and enrolled.

Service Plan Development
The Plans will review the comprehensive assessment and service plan completed by the supportive living facility (SLF) licensed nurse to verify that all of the participants' needs are identified and included in the service plan. The Plans will work with the SLF staff to incorporate any changes to the assessment and/or service plan. In all aspects of service planning, the participant is the key member of the service planning team. The State will ensure that service plan development is conducted in the best interest of the participant and will be based on individual preferences and assessed needs. The Medicaid agency is responsible for monitoring program compliance for the comprehensive assessment and service plan for participants enrolled in the MMAI and MLTSS. The Plans will assist the participant with arranging for and coordinating outside services. These services will be communicated to SLF staff for inclusion on the service plan.

Transition of Service Plans
In order to provide a more seamless transition for participants who are enrolled in the existing waiver, the Plans will maintain the current service plans for at least 180 days, unless changed with the consent and input of the participant and only after completion of comprehensive needs assessment. Service plans will be transmitted from the Medicaid Agency to the Plans prior to the effective date. Eligibility reassessments that come due during this 180 day transition will be conducted by the Medicaid agency as described in the existing waiver.

Health, Safety and Welfare Roles and Responsibilities
The health, safety and welfare of the waiver participants who are enrolled in the Plans will be the responsibility of the Medicaid agency and the Plans. This will include monitoring the participant to assure needs are being met, assuring providers are qualified, and reporting and following up on critical incidents. The Plan will have established processes and procedures in place to monitor access, quality, and appropriateness of service issues. Critical events and incidents must be reported and identified, issues routed to the appropriate department within the Plans, to the Medicaid agency as required by

administrative rule, and when indicated, to the investigating authority described in Appendix G. The procedures will include processes for ensuring participant safety while the appropriate authority conducts its investigation. The Plans will review all incidents to identify trends and patterns and to determine whether individual or systemic changes are needed. The Medicaid agency will oversee Plans to assure compliance with federal waiver requirements and ensure participants' needs are being met.

Quality Improvement Strategy:
For participants enrolled in an MCO, the QIS will be reviewed and modified to assure that the Plans are complying with the waiver assurances in all delegated areas. For example, The Plans will primarily be responsible for overall care coordination, prior authorization of waiver services, qualified provider enrollment, health, safety and welfare and quality assurance and quality improvement activities. Participants enrolled in MCOs will be included in the overall representative sampling methodology. The Medicaid agency will monitor performance of the Plans through receipt and analysis of reported data, onsite visits, desk audits and interviews. The Plans will submit performance data at least quarterly, and more often as indicated by the contract. The Medicaid agency will schedule onsite reviews and desk audits throughout the waiver year for the representative sample and validation reviews. The Medicaid agency will meet quarterly with the Plans to identify and analyze trends based on scope, severity, changes and opportunities for system improvement.

In addition to waiver assurances, HFS will ensure compliance with implementation of the American Recovery and Reinvestment Act requirements for Indians, to include:

--HFS shall notify the Plans which Providers have been designated as Indian Health Care Providers.

--The Plans shall notify American Indian Enrollees upon enrollment, and annually thereafter, of their right to receive services at an Indian Health Care Provider.

--The Plans shall reimburse an Indian Health Provider at least the full encounter rate for fee-for-service rate established by the Department for that Provider, regardless of whether the Provider is an Affiliated Provider.

--The Plans shall not impose any co-payment on Enrollees identified as American Indian for a Covered Service received from an Indian Health Care Provider or any Medicaid Provider.

--The Plans shall not impose cost sharing on Enrollees identified as American Indian if the Enrollees have ever received services from an Indian Health Care Provider.

--An enrollee identified as an American Indian is exempt from all cost sharing if the Enrollee has ever received a Referral from an Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U).

--The Plans shall not limit an Enrollee identified as an American Indian to I/T/U in the State of Illinois.

--HFS does not and will not waive the requirement that payments are consistent with efficiency, economy and quality.

--The Plans' contracts are compliant with the federal regulations that the managed care entities make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR sections 447.45 and 447.46.

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	Main, 1, 2, 6.i, 7, Att
Appendix A – Waiver Administration and Operation	3
Appendix B – Participant Access and Eligibility	
Appendix C – Participant Services	2.f, a.ii Quality Impr
Appendix D – Participant Centered Service Planning and Delivery	
Appendix E – Participant Direction of Services	
Appendix F – Participant Rights	
Appendix G – Participant Safeguards	

Component of the Approved Waiver	Subsection(s)
Appendix H	
Appendix I – Financial Accountability	3.g.iii
Appendix J – Cost-Neutrality Demonstration	2

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:
Revise the delivery system to expand care coordination and waiver services delivery system to include those participants whose waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) for the dual eligible. For those who voluntarily enroll in MMAI, both Medicare and Medicaid covered services will be covered and coordinated by the Health Plans. For those who are dual eligible, but opt not to participate in MMAI, the MA will administer and provide waiver and other Medicaid covered services under a concurrent 1915 b/c waiver. This managed Long-term Supports and Services (MLTSS) will use the same Health Plans chosen to provide MMAI. Services are designed in a similar manner as the Integrated Care Program.

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*):
Illinois Supportive Living Program

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.0326
Waiver Number:IL.0326.R03.03
Draft ID: IL.005.03.03

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

E. **Proposed Effective Date of Waiver being Amended: 07/01/12**
Approved Effective Date of Waiver being Amended: 07/01/12

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:

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:

The State is submitting a concurrent 1915(b) waiver (1915(b) MLTSS waiver) at the same time as this 1915(c) waiver amendment. The 1915(b) MLTSS waiver will allow the State to mandatorily enroll into managed care the dual population receiving Long-term Support Services (LTSS) who opt-out of the Medicare Medicaid Alignment Initiative (MMAI) described below, which is under 1932(a) authority of the Social Security Act. For those participants who wish to opt-out of the MMAI and are receiving LTSS, the State will provide LTSS and other Medicaid covered State Plan services, using the same managed care Health Plans chosen for MMAI. These participants will not have their Medicare covered services covered or coordinated by the Health Plans. For those who opt-out of the MMAI demonstration and are receiving LTSS, enrollment with a Health Plan is mandatory in order to receive Medicaid LTSS, transportation, and specific behavioral health services.

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 beneficiaries on a mandatory basis into managed care organizations (MCOs) through the Integrated Care Program, which is a full-risk capitated program.

The SPA is operated under the authority granted by section 1932(a)(1)(A) of the Social Security Act. Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions

of section 1902 of the Act on statewideness, freedom of choice or comparability. The authority will not be used to mandate enrollment of Medicaid beneficiaries who are Medicare eligible, or who are Indians, except for voluntary enrollment as indicated in D.2.ii of the SPA.

Effective March 1, 2014, waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) for dually enrolled Medicare-Medicaid participants. Under the MMAI, Illinois and CMS will contract with Health Plans to coordinate the delivery of and be accountable for all covered Medicare and Medicaid services for participating Medicare-Medicaid enrollees. For waiver participants who choose to opt-out of the MMAI, the State will provide Long Term Support and Services (LTSS) and other Medicaid covered State Plan services, using the same managed care Health Plans chosen for MMAI.

Initial implementation for the MMAI is for the greater Chicago and Central Illinois regions where participants will be able to voluntarily enroll in MMAI. Passive enrollment will begin June 1, 2014. The SPA amendment was submitted September 2013 to include the MMAI population.

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 demonstration will operate 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 IL Supportive Living Program (SLP) serves individuals age 65+ and persons with physical disabilities ages 22-64 who are in need of assist. with ADLs. Supportive living facilities (SLFs) must have a minimum of ten apts. and may have a maximum of 150. Each apt. is private with a locked door and is required to have a living area, bedroom, kitchen and a private bathroom. Partic. only share double occupancy apts by choice. Partic. may receive visitors of their choice at any time. They may also come and go from the SLF as they choose. Common areas are required in the bldg. for dining, socializtion and partic. personal use.

The SLP provides partic. with indiv. svcs. incl: medication oversight, assessments, well-being checks, meals, assist. with ADLs, laundry and housekeeping, planned activities and assist. with arranging outside svcs.

Access to the larger commun. is promoted through sched. activities both on-site and outside of the SLF. Opportunities for commun. involvement are communicated to partic. in writing through activity calendars and newsletters, as well as verbally. Examples of activities that provide an opportunity for commun. access outside of the SLF include: musical events, religious services, educational and charity/volunteer opportunities, sporting events, shopping, museum trips, scenic drives and fishing. Waiver partic. are encouraged to provide input regarding activities based on their preferences. SLF staff also encourage individual participation in the commun., such as volunteering or taking college classes. The required resident assessment includes a section to identify a resident's interests. Additionally, commun. members are invited into the SLF as part of activities. Medical professionals provide info. on health and wellness and children's groups provide musical entertainment and social interaction. Faith-based groups are also common visitors.

The purpose of the SLP is to promote the health and indep. of partic. by offering the necessary supports and svcs. The SLP is an alternative to nursing facility care and also to living alone in the commun. where comprehensive support services may not be available.

The Goals of the SLP include:

Health and Safety
A number of waiver partic. enter SLP directly from their own home where they might not be receiving regular assist. with supports such as medication oversight, meals, hygiene, well being checks and overall health monitoring. The SLP provides these svcs. which assists partic. in maintaining their health and indep.

Quality of Life
Partic. who previously resided in nursing facilities are able to experience more freedom and encouraged to be more indep. in a SLF.

They are free to come and go from the SLF, decorate their own apt., participate in activities of their choosing, cook their own meals or eat in the SLF's dining room. Partic. also are involved with the development of an individualized service plan, which reflects the svcs. and care they need and choose. Additionally, partic. who previously lived in their own homes may have been isolated and not have had regular opportunities for interaction with others and their commun. The SLP encourages socialization within the SLF and with the commun. at large.

Increased Service Options
The SLP provides partic. with another option for support svcs. that promote health and safety and encourage independence. The licensed Assisted Living Program in IL is not subsidized by public funds and therefore is not an affordable option for many people. Independent living and subsidized housing do not offer many of the supports waiver partic. need, such as medication oversight. Without the SLP, nursing facilities are the only other care option for many people of low income who require more services than they can obtain in their home.

Cost Savings
With a Medicaid reimb. rate of 60% of the average weighted daily reimb. rate for nursing facilities (72% for the dementia program), the SLP decreases the State's cost of care for partic. who otherwise would be insitutionalized.

The main objective of the SLP is to decrease and deflect the number of individuals in nursing facilities who are not in need of that level of care.

HFS(Medicaid agency) is responsible for oversight of the SLP. Svcs. are accessed on the local level at individual SLFs. Applications for Medicaid are also made at the state level at DHS Family and Community Resource Centers located throughout the state.

Traditional svc. delivery methods are used, however, partic. are encouraged to make their own decisions about the svcs. they receive. The svcs. provided are based on the partic.'s individual needs and choices.

Effective February 1, 2013, the State will deliver care coordination and waiver svcs. through a mandatory managed care delivery system for those waiver partic. enrolled in the Integrated Care Program (ICP). The ICP is implemented in the IL areas of suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake and Will Counties. Future areas/MCO plans will affect the population similarily.

Effective March 1, 2014, the State will include dually enrolled Medicare and Medicaid waiver partic. to the managed care delivery system. Waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) or the Managed Long-term Supports and Services (MLTSS) through a concurrent 1915(b)waiver. Under the MMAI, Illinois and CMS will contract with Health Plans to coordinate the delivery of and be accountable for all covered Medicare and Medicaid services for participating MMAI enrollees. For those partic. who wish to opt-out of the MMAI, long term support services, including waiver services, and other Medicaid services will be provided using the same managed care Health Plans as chosen by the State for MMAI. Initial implementation for the MMAI is for the greater Chicago and Central IL regions.

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:
The Affordable Assisted Living Coalition (AALC), an advocacy group for supportive living facilities, was involved with the development of the SLP waiver renewal. Members and staff provided feedback and comments related to care planning, assessments and quality manangment. Conference calls and meetings were conducted in order to promote discussion and obtain input.

The Medicaid Advisory Committee, Long Term Care subcommittee was also consulted as part of the waiver renewal process. Members of the Committee are regularly informed of the status of the waiver and provide input and guidance to the Medicaid agency on issues related to the SLP.

Additionally, staff from the Medicaid agency serve on the Older Adult Services Advisory Committee. This group was established by the Governor and state legislature to develop a more comprehensive system of services for seniors and to create a more robust system of home and community-based services. Ideas and recommendations from the Committee for the development of a statewide vision of long term care were used in the creation of the SLP waiver renewal. Additionally, regular briefings and updates on the SLP program are provided during the Committee's meetings.

Proposed administrative rule changes related to the waiver for the Supportive Living Program are always presented to the AALC and all supportive living facility providers for input and feedback. A public comment period during the rulemaking process also allows interested persons an opportunity to comment.

A notice of the proposed waiver renewal and changes was submitted as required for the Notice of Tribal Governments on April 13, 2012. No response was received.

Integraged Care Program: In compliance with CFR 438.50(b)(4) the State researched various integrated care models through literature and reaching out to other state Medicaid programs. The state held many meetings with clients, client advocates and providers to assist with the development of the program, development of the RFP to solicit the contractors, and to guide the implementation of the program. The list of represented entities included as invitees and attendees is found under B.4. of the approved 1932(a) SPA. The State will continue to have meetings with representatives from the above listed entities throughout implementation and on an on-going basis. These meetings will be through ad-hoc requests and regularly scheduled stakeholder meetings. Public input for future MCOs will be modeled in the same fashion.

A notice of the proposed waiver amendment for ICP was submitted as required for the Notice of Tribal Governments on September 28, 2012.

Medicare Medicaid Alignment Initiative (MMAI)

The State held the first MMAI stakeholder webinar/meeting on April 18, 2013. Over 100 questions from that session were submited to HFS during the webinar. Answers were posted June 14, 2013 and can be found on the HFS Medicare-Medicaid Alignment Initiative webpage. Additional stakeholder meetings are being scheduled and will be held regularly.

HFS has maintained email accounts for receiving questions from the public about ICP since December 2012 and the MMAI since April 2013. HFS reads the emails daily and responds individually by phone or email.

The email addresses are: HFSCareCoord@illinois.gov and HFSMMAI@illinois.gov .

The State issued the tribal government notifications about MMAI on April 29, 2013.

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:
Cunningham

First Name:
Kelly

Title:
Deputy Administrator for Medical Programs

Agency:
Department of Healthcare and Family Services

Address:
201 South Grand Avenue

Address 2:

City:				
State:	**B. If**	Springfield		
Zip:		**Illinois**		
Phone:				
applicable, the State operating agency		62763		
Fax:				
representative with whom CMS should		(217) 782-2570	**Ext:**	**TTY**
E-mail:				
communicate regarding the waiver is:		(217) 782-5672		
		kelly.cunningham@illinois.gov		
Last Name:				
First Name:				
Title:				
Agency:				
Address:				
Address 2:				
City:				
State:		**Illinois**		
Zip:				
Phone:				
			Ext:	**TTY**
Fax:				
E-mail:				

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: Kelly Cunningham

Submission Date:

State Medicaid Director or Designee

Feb 6, 2014

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

Last Name:

Eagleson

First Name:

Theresa

Title:

Administrator, Division of Medical Programs

Agency:

Department of Healthcare and Family Services

Address:

201 South Grand Avenue, 3rd Floor

Address 2:

City:

Springfield

State: **Illinois**

Zip:

62763

Phone:

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

Fax:

(217) 782-5672

E-mail:

teresa.eagleson@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:

Effective February 1, 2013, the State will deliver care coordination and waiver services through a mandatory managed care delivery system for those waiver participants age 19 and older who are enrolled in the Integrated Care Program (ICP). The

program is implemented in the Illinois areas of suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake and Will Counties. The Medicaid Agency contracted with two Managed Care Plans (Plans). Participants have the choice of plans.

Between February 2013 and January 2014, the program will be expanded to the following counties: Winnebago, Boone, McHenry, Rock Island, Mercer, McHenry, Knox, Stark, Peoria, Tazewell, Logan, Menard, Sangamon, Christian, Macon, DeWitt, McLean, Piatt, Ford, Champaign, Vermillion, Madison, St. Clair, Clinton and the City of Chicago. Outside Cook and the Collar Counties, each county will have no more than two MCOs with the exception of seven counties in Northern and Central Illinois that will have three MCOs.

Effective March 1, 2014, the delivery system will include those participants whose waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) for the dual eligible. For those who voluntarily enroll for MMAI, both Medicare and Medicaid covered services will be covered and coordinated by the Health Plans. For those who are dual eligible, but opt not to participate in MMAI, the MA will administer and provide waiver and other Medicaid covered services under a concurrent 1915b/c waiver (1915 b MLTSS waiver). This Managed Long-term Supports and Services (MLTSS) option will use the same Health Plans chosen to provide MMAI.

Eight Managed Care Organizations (Plans) were chosen by the MA for MMAI. Participants will have the choice of six Plans in the greater Chicago region and two Plans in the Central Illinois region. The MMAI demonstration project will provide coordinated care to Medicare-Medicaid enrollees in the Chicagoland area, including Cook, DuPage, Kane, Kankakee, Lake and Will counties, as well as throughout central Illinois, including Champaign, Christian, DeWitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell and Vermillion counties.

In order to provide a more seamless transition from the existing care coordination processes and service plans for participants who are currently in the waiver, the Plans will maintain the current service plans for atleast 180 days, unless changed with the consent and input of the paricipant, and only after completion of a comprehensive needs assessment. Service plans will be transmitted from the Medicaid agency prior to the effective date. These existing HCBS eligible participants will remain eligible for these services until the time of the participant's redetermination. In the interim, Plans are expected to assess that the participant's needs are being met. Eligibility reassessments that come due during this 180-day transition will be conducted by the Medicaid agency as described in the existing waiver.

Plans will recruit providers. The 180-day period in which participants may maintain a current course of treatment with an out-of-network provider also includes HCBS waiver providers. The State will institute an "any willing provider" contractual clause that will require Plans to offer contracts to any willing provider that meets quality and credentialing standards. Therefore there should be little need for transition to a different provider. After the initial contracting period, Plans will be allowed to impose a known quality standard and to terminate contracts with underperforming providers. Finally, during readiness review, the State will only authorize Plans that meet the State's network adequacy determination to move forward. In the first year of the MMAI and MLTSS options, Plans are required to contract with any willing and qualified providers currently approved to provide waiver services.

If a transition would be necessary, the participant will be consulted in the transition, including the selection of the network provider. If the participant does not agree to the transition, the current provider, including PCPs, may enter into a Single Case Agreement with the Plan. If the provider does not choose to enter into a Single Case Agreement with the Plan, the participant will be required to transition to a network provider that is capable of meeting the participant's needs.

Through the state's transition to managed long term services and supports, the state will communicate to CMS its implementation progress, timeliness with transition milestones and demonstration of the managed care plans' compliance with federal waiver assurances. The state will submit this information to CMS through quarterly monitoring reports until July 1, 2015.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the

state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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:
Division of Medical Programs
(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:

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:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

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.:*
Local Case Coordination Units perform initial level of care evaluations.

Effective February 1, 2013, the State will deliver care coordination and waiver services through a mandatory managed care delivery system for those waiver participants enrolled in the Integrated Care Program (ICP). The program is being implemented in the Illinois areas of Suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake and Will Counties. The State is implementing the managed care delivery system under the State plan authority [Section 1932(a)]. Future MCOs will be used in a similar fashion over time. They are being designed in the same fashion, but will also serve dual eligibles.

The ICP is a program for older adults and adults with disabilities, age 19 and over, who are eligible for Medicaid, but not eligible for Medicare. The Medicaid agency contracted with two managed care plans (Plans) Aetna Better Health and IlliniCare Health Plan, to administer the program. Participants have the choice of Plans.

The program is expanding to the following counties: Winnebago, Boone, McHenry, Rock Island, Mercer, Knox, Stark, Peoria, Tazewell, Logan, Menard, Sangamon, Christian, Macon, DeWitt, McLean, Piatt, Ford, Champaign, Vermillion, Madison, St. Clair, Clinton and the City of Chicago. Purusant to an RFP, the following Plans, in addition to the two named above, were selected to participate in the expanded program: Community Care Alliance of Illinois (CCAI), HealthSpring of Illinois, Meridian Health Plan, Health Alliance and Molina Healthcare of Illinois.

Effective March 1, 2014, the delivery system will include those participants whose waiver servcies will be administered under the Medicare Medicaid Alignment Initiative (MMAI) for the dual eligible. For those who voluntarily enroll for MMAI, both Medicare and Medicaid covered services will be covered and coordinated by the Health Plans. For those who are dual eligible, but opt not to participate in MMAI, the MA will administer and provide waiver and other Medicaid covered services under a concurrent 1915b/c waiver. This Managed Long-term Supports and Services (MLTSS) 1915 (b) waiver will use the same Health Plans chosen to provide MMAI.

Services are designed in a similar manner as ICP. Eight Managed Care Organizations (Plans) were chosen by HFS for MMAI. Participants will have the choice of six Plans in the greater Chicago region and two Plans in the Central Illinois region. The MMAI demonstration project will provide coordinated care to more than 135,000 Medicare-Medicaid enrollees in Chicagoland, including Cook, DuPage, Kane, Kankakee, Lake and Will counties, as well as throughout central Illinois, including: Champaign, Christian, DeWitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Start, Tazewell and Vermillion counties.

For those waiver participants enrolled in an MCO, the Plans will be responsible for care coordination, service plan oversight, participant safeguards, prior authorization of waiver services, and quality assurance and quality improvement activities.

Local Case Coordination Units perform initial level of care evaluations for participants enrolled in ICP, MMAI and MLTSS.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

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

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Medicaid agency reviews the screening results forms completed by local Case Coordination Units, and Department of Human Services, Division of Rehabilitation Services for all new waiver participants annually, and bi-annually for participants in the dementia program.

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

The Medicaid agency's contracts with the MCOs specify the following for waiver performance measures: 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. For many of the measures, the sources are MCO reports and External Quality Review Organization (EQRO) record reviews. The data source for several measures includes customer satisfaction and quality of life surveys. MCOs collect this data either by evaluating 100% of records or through a representative sample of records, according to the specific performance measure. As part of the Medicaid agency's quality oversight and monitoring of the waiver providers, the EQRO will perform quarterly onsite audits of the enrollee care plans through record reviews. This information will be submitted to the Medicaid agency for review and analysis. MCOs are required to submit quarterly reports for some performance measures using a format required by the Medicaid agency. For each performance measure, the contracts specify numerators, denominators, sampling approaches and data sources. The Medicaid agency has provided the MCOs with templates for use in submitting quarterly reports. MCOs also present the results to the Medicaid agency in quarterly meetings. MCO contracts include sanctions for failure to meet requirements for submission of quality and performance measures.

The Medicaid agency contracts with Health Services Advisory Group (HSAG) to serve as EQRO. As part of the Medicaid agency's quality oversight and monitoring of managed care enrollees, the EQRO performs quarterly onsite

audits of enrollee records. Per the Medicaid agency's contract with HSAG, upon completion of record reviews, HSAG will provide an enrollee specific summary of findings by measure, a summary by plan and also by waiver. Recommendations will be provided as appropriate. The report will include: summary of non-compliance related to specific performance measures, overall summary of record review findings, and recommendations for remediation of non-compliance. The Medicaid agency and EQRO will work collaboratively to follow up with the MCOs to ensure remediation occurs within the required time frames.

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 Medicaid agency reviews the screening results forms of all new waiver participants annually. These forms are completed by Case Coordination Units and Department of Human Services, Division of Rehabilitation Services staff. Medicaid agency staff audit the forms to verify they are complete and accurate.

Oversight of MCOs:

The State's Quality Improvement System (QIS) has been modified to assure that the plans are complying with the federal assurances and performance measures that fall under the functions delegated to them by the Medicaid agency. The sources of discovery vary, and the sampling methodology for discovery is based on either 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 Medicaid agency's sampling methodolgy is based on a statistically valid sampling methodology that pulls proportionate samples from the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The Medicaid agency will pull the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

Once the MA selects the sample, it is provided to the 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 requrie 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. The MCOs will report remediation activities to the MA at least quarterly.

For the performance measures that do not require record reviews, the MCOs will be sending routine reports (some monthly and some quarterly) to the MA. These reports will contain discovery and remediation activity and will be reviewed at least quarterly. Data sources may include the Medicaid Management Information System, the MCOs' Information Systems, the MCOs' critical incident reporting systems and other data sources as indicated in the waiver.

The MA will meet quarterly with the MCOs to assess compliance with the waiver assurances and to identify and analyze trends based on scope and severity. Remediation activities will be reviewed and systems improvements will be implemented.

As part of the State's oversight of the EQRO, the MA has developed a performance measure to assure that the EQRO is completing record reviews as required through their contract. If non-compliance is noted, the EQRO will develop a corrective action plan to remediate the problem.

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	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		

Function	Medicaid 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
#/% of new waiver participants' screening results forms submitted by CCU or DHS Division of Rehabilitation Services (DRS) as part of the DON process that were complete and accurate. Numerator: Number of new waiver participants with screening results forms submitted by CCU or DRS that were complete and accurate. Denominator: Total number of screening results forms for new waiver participants.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
#/% of new dementia prog. waiver partic. screening results forms submitted by CCU or DHS Div. of Rehabilitation Svcs. (DRS) as part of the DON process that were complete and accurate. Num: # of new dementia prog. waiver partic. with screening results forms submitted by CCU or DRS that were complete and accurate. Den: Total number of screening results forms for new dementia prog. waiver partic.

Data Source (Select one):

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

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

Performance Measure:
#/% of participant reviews conducted by the EQRO according to sampling methodology specified by the waiver. Num.: # of participant reviews conducted by the EQRO

according to the sampling methodology specified in the waiver. Den: Total # of participant reviews by the EQRO required according to sampling methodology.

Data Source (Select one):
Other
If 'Other' is selected, specify:
EQRO 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: EQRO	**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: EQRO	**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:
#/% of supportive living facility providers utilized by the MCO that are an enrolled Medicaid provider. Num.: # of supportive living facility providers utilized by the MCO that continued to maintain certification. Den: Total number of enrolled certified supportive living facility providers utilized by the MCO.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: MCO	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: MCO	**Annually**
	Continuously and Ongoing
	Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid agency will conduct routine programmatic and fiscal monitoring for the MCOs.

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

For the MCO, the Medicaid agency's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The Medicaid agency will pull the sample annualy and adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If a new waiver participant's screening results form were found to be incomplete or inaccurate, including those in the dementia program, the Medicaid agency would contact the Department on Aging for local Case Coordination Units or the Department of Human Services, Division of Rehabilitation Services to bring errors to their attention so remediation could occur. The screening results form would be revised by the screening agency or a new form completed. Medicaid agency staff would review the revised or new form to verify remediation had occured. If the problem resulted in a non-payable service period for the participant or a determination that the participant was ineligible for waiver services, the Medicaid agency would recover payments. If persistent problems with a specific local Case Coordination Unit or Department of Human Services employees were identified, the Medicaid agency would seek a meeting with the respective state agencies to discuss remedication, such as staff training or personnel action. This same process applies to the dementia program.

For the Integrated Care Program (ICP), the EQRO completes case reviews and reviews the case review scheduling/process to determine reasons for reviews not being conducted. If remediation is not within 90 days, the EQRO reviews procedures and submits a plan of correction to the Medicaid agency. The Medicaid agency follows-up for completion.

Upon discovery of a MCO utilizing a provider that is not an enrolled Medicaid provider, the MCO is notified to change the provider. Training will be required for MCO case managers. Remediation shall occur immediately.

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:	**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)	22	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:

Potential Supportive Living Program waiver participants must also be screened and found to be in need of nursing facility level of care and appropriate for placement in a supportive living facility. Additionally, individuals must be without a primary or secondary diagnosis of a developmental disability and serious and persistent mental illness.

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:

Supportive living facilities serving people with physical disabilities do not have a maximum age limit after a resident is admitted. Although the participant cannot be older than age 64 at the time of admission, participants are able to remain in the facility after that age.

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.

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:

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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:

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	11700
Year 2	12600
Year 3	13000
Year 4	13400
Year 5	13800

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:

The waiver provides for the entrance of all eligible persons.

Participants in the Supportive Living Program waiver must be age 65 years or older, or be ages 22-64 and have a physcical disability, as determined by the Social Security Administration.

Potential participants must also be screened by the Medicaid agency or its designee and found to be in need of nursing facility level of care and appropriate for placement in a supportive living facility (SLF).

All potential participants must be checked against two state and one national sex offender registration websites and have a tuberculin skin test in accordance with the Control of Tuberculosis Code.

Any individual wishing to participate in the Supportive Living Program waiver may not receive services from any other HCBS waiver.

Potential participants must apply and be determined eligible for Medicaid.

Finally, individuals must have the resources to pay for the cost of room and board and to receive a personal allowance, both of which are established by the Medicaid agency.

For participants enrolled in MCOs, State-established policies governing the selection of individuals for entrance to the waiver will remain the same for all participants. Initial waiver eligibility will be conducted by the same persons as designated in the existing waiver and be based on the same objective criteria as for all. Selection of entrants does not violate the requirement that otherwise eligible individuals have comparable access to all services offered in the waiver.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

   §1634 State

   SSI Criteria State

   209(b) State

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

No

Yes

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

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

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

SSI recipients

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:

Public Law 111 - 148 - Patient Protection and Affordable Care Act:

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

Medically needy without spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.*

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (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 participants equals the maximum income an individual 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 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-5-a 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 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 (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 that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

Other
Specify:

The Medicaid agency has Intergovernmental Agreements with the the Department on Aging and the Department of Human Services, Division of Rehabilitation Services to perform initial level of care determinations for potential waiver participants. The Medicaid agency conducts reevaluations annually.

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:

As stated in 89 IL Admin. Code, Chap. II, Section 220.605, contractors of the Department on Aging who perform initial level of care evaluations for potential waiver participants must be:

1. A registered nurse, or have a Bachelor of Science in Nursing, or have a Bachelor 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 a licensed practical nurse with one year of program experience which is defined as assessment of and provision of formal services for the elderly and/or authorizing service provision.

The Department of Human Services, Division of Rehabilitation Services requires a master's degree with major coursework in rehabilitation, counseling, guidance, psychology or a closely related human services field, OR current licensure in the State of Illinois as a practical nurse, OR a Bachelor degree in social service.

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 Supportive Living Program waiver, or initial level of care determination, is through the Universal Screening process which become law on July 1, 1996 (Public Act 89-499). This law requires all individuals 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 individuals identified through the screening process as needing nursing facility level of care are afforded the opportunity to select a supportive living facility as long as their needs can be met in that setting.

The necessity for long term care is based on the determined need for a continuum of home and community-based services that ultimately prevent inappropriate or premature placement in a group care facility. The extent and degree of an individual's need for long term care is determined on the basis of consideration of pertinent medical, social and psychological factors as measured by application of the DON (IL-402-1230).

The DON is composed of three parts: demographic, cognitive status and functional status. The Mini-Mental Status Examination (MMSE) Section includes eleven items. The first two items are used to measure a person's orientation. The third question tests the ability of the applicant to register, i.e., learn and remember new information. The fourth item measures the person's ability to attend to a task and perform a mental function. The fifth item measure the person's short term recall. Remaining items is this section test a person's basic ability to use and understand words.

The functional status section assesses the level of assistance a person requires with activities of daily living, including: eating, bathing, grooming, dressing, transferring, continence, managing money, telephoning, preparing meals, laundry, housework, outside home, routine health, special health and being alone.

Reevaluations are performed annually by the Medicaid agency through examination of the Resident Assessment Instrument (RAI). The RAI is a comprehensive assessment tool that is completed by the provider near the time of the waiver participant's admission and annually thereafter. It must also be updated as needed to reflect any significant changes in a participant's condition. The annual Level of Care Determination (LOCD) tool captures scores from specific sections of the RAI, including cognitive patterns, physical functioning and health conditions. Portions of the RAI are scored based on a participant's independence level. For example, a participant who requires no assistance with dressing would be scored as "0", or independent. A participant who needed cuing and reminders for dressing would score a "1", or supervision. Other sections identify health conditions and pain levels.

For the purpose of reevaluation, scores from specific sections of the RAI are examined. The sections reviewed for reevaluation assess independence levels in areas including: cognition, decision making, transferring, dressing, eating, toileting, personal hygiene, bathing, medication management, managing money, preparing meals/snacks, housekeeping and laundry. Assessments of these areas reflect services provided in the Supportive Living Program waiver and used during initial evaluation, which makes them relevant for reevaluation.

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:

As described in section B 6 d, the Determination of Need (DON) is the standardized assessment tool used to perform initial level of care evaluations. Assessors complete the DON by asking questions of the potential waiver participant and/or his/her designated representative. Additional information may be gathered from physicians and other health care providers.

Annual reevaluations for waiver participants are performed by the Medicaid agency's Bureau of Long Term Care. As described in section B 6 d, sections of the Resident Assessment Instrument (RAI) are reviewed for each waiver participant. A Level of Care Determination form is then completed to verify the waiver participant continues to require the services provided by the Supportive Living Program waiver. Medicaid agency staff may also interivew the participant, his/her designated representative, other health care providers and facility staff to obtain more information or clarification.

Waiver particpants who do not meet level of care requirements based on the initial or the annual level of care evaluation are provided the opportunity to appeal the decision to the Medicaid agency.

For participants enrolled in a MCO, the re-evaluation will be conducted by the Medicaid agency's Bureau of Long Term Care as described in the existing waiver.

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:

Reevaluations are conducted by the Medicaid agency every calendar year.

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:

Medicaid agency staff perform reevaluations. Most are Health Facilities Surveillance Nurses whose qualifications are:

·Current licensure as a Registered Nurse in the State of Illinois.

·Graduation from an approved nursing education program resulting in an associate or a diploma degree in nursing and three years of professional nursing experience OR

·Bachelor's degree in nursing and two years of professional nursing experience, OR

·Master's degree in nursing

Staff may also be Medical Assistance Consultant II's. Their qualifications are:

·Knowledge, skill and mental development equivalent to completion of four years of college with courses in medical social work.

-Two years professional experience in fields related to medical social work.

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):*

Medicaid agency procedures require annual on-site certification reviews be completed for all supportive living facilities (SLF). Policy requires that Level of Care Determination (LOCD) forms be completed for each waiver participant during these reviews. Medicaid agency staff track due dates for annual reviews to ensure they are conducted within 60 days of the original certification date.

A list of all current waiver particpants residing in the supportive living facility is compiled from the long term care database and provided to Medicaid agency regional staff. Additionally, an automated tool with a form designated for each resident on the long term care database list requiring an annual LOCD is provided to Medicaid agency regional staff so that no waiver participant is excluded.

The automated LOCD tool is reviewed after the on-site annual certification review is finished to verify LOCDs were completed for each waiver participant or there is justification indicating why not, such as death.

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 records of initial level of care evaluations are be kept by the Case Coordination Units and Department of Human Serivces, Division of Rehabilitation Services for a minimum of three years. Records of reevaluations completed by the Medicaid agency are kept for a minimum of three years by Supportive Living Program providers and are also maintained for a minimum of three years by the Medicaid agency.

For participants enrolled in a MCO, the Plans will also maintain a copy of the forms. The record retention requirements will be the same for the MCOs as required by CMS. The minimum is three years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number/percent of new waiver applicants who have required initial level of care assessment (DON) prior to admission. Numerator: Number of new waiver

applicants who have required initial level of care assessment (DON) prior to admission. Denominator: Total number of new waiver applicants requiring initial level of care evaluation.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Event 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: MCO	**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: MCOs	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
Number/percent of new dementia program waiver applicants who have required initial level of care assessment (DON) prior to admission. Numerator: Number of new dementia program waiver applicants who have required initial level of care assessment (DON) prior to admission. Denominator: Total number of new dementia program waiver applicants requiring initial level of care evaluation.

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):*
	Weekly	**100% Review**

State Medicaid 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: Bi-annually	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Event 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: MCOs	**Annually**	**Stratified** Describe Group:
		Other

	Continuously and 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: MCO	**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:
Number/percent of enrolled waiver participants evaluated annually as specified in the approved waiver. Numerator: Number of enrolled waiver participants evaluated annually as specified in the approved waiver. Denominator: Total number of enrolled waiver participants who required annual evaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Level of Care Determination form

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:
Number/percent of enrolled dementia program waiver participants evaluated annually as specified in the approved waiver. Numerator: Number of enrolled dementia program waiver participants evaluated annually as specified in the

approved waiver. Denominator: total number of enrolled dementia program waiver participants who required annual reevaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Level of CAre Determination form

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:

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:
Number/percent of waiver participants' annual level of care (LOC) determinations completed accurately. Numerator: Number of waiver participants' annual LOC determinations completed accurately. Denominator: Total number of annual LOC determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Level of Care Determination forms and comprehensive assessments.

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 = +/-5
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:
Number/percent of waiver participants' annual LOC determinations completed by qualified Department staff. Numerator: Number of waiver participants with annual LOC determinations completed by qualified Department staff. Denominator: Total number of waiver participants' LOC determinations completed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Level of Care Determination forms

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:
Number/percent of dementia program waiver participants' annual level of care (LOC) determinations completed accurately. Numerator: Number of dementia program waiver participants' annual LOC determinations completed accurately. Denominator: Total number of dementia program waiver participants' annual LOC determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Level of Care Determination forms and comprehensive assessments.

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:
Number/percent of dementia program waiver participants' annual LOC determinations completed by qualified Department staff. Numerator: Number of dementia program waiver participants with annual LOC determinations completed by qualified Department staff. Denominator: Total number of dementia program waiver participants' LOC determinations completed.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Level of Care Determination forms

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The state Medicaid agency is responsible for insuring individual problems are resolved.

Remediation for Initial Level of Care assessments:
When it is discovered that an initial level of care assessment has not been completed for a waiver participant, the LOC assessment is completed. If a participant is found ineligible, he/she is notified in writing by the Medicaid agency and provided appeal rights. Supportive Living Facility staff would assist the person with relocation assistance to another program or setting of the individual's choice.

Regardless of eligibility for waiver services, the Medicaid agency recovers all reimbursements paid for identified non-payable service periods as the result of initial level of care evaluations not being completed prior to admission to the waiver program. Medicaid agency staff change the date of eligibility for waiver services in the MMIS to correspond with the first day of the allowable service period. On-line edits are then posted to the system to recover any reimbursement for waiver services during the non-payable service period.

Additionally the facility may have to develop and implement a plan of correction. The state Medicaid agency performs a follow-up visit to determine compliance with initial level of care assessment requirements. Persistent non-compliance results in sanctions, including but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, Medicaid agency staff from the Bureau of Long Term Care would assist waiver participants with identifying possible relocation options, including transferring to another SLF.

Remediation for Annual Level of Care Assessments:
When it is discovered that an annual level of care assessment has not been completed for a waiver participant, the LOC assessment is completed.

If a person is found to be ineligible for waiver services during an annual level of care assessment, he/she is notified in writing by the Medicaid agency and provided appeal rights. Supportive Living Facility staff would assist the person with relocation assistance to another program or setting of the individual's choice.

Accuracy of Level of Care Assessments:
If an annual level of care assessment is not completed accurately by Department staff, the LOC assessment is revised. If the participant in found ineligible after the LOC assessment, he/she is notified in writing by the Medicaid agency and provided appeal rights. Supportive Living Facility staff would assist the person with relocation assistance to another program or setting of the individual's choice.

Additionally, Department supervisory staff also provide technical assistance/training for staff who complete inaccurate assessments. Persistent inaccuracy could result in staff administrative action as appropriate.

Remediation for following approved waiver policies and procedures:
If an annual level of care assessment is not completed by qualified Department staff, the assessment would be completed again by someone who was qualified. If the participant in found ineligible after the LOC assessment, he/she is notified in writing by the Medicaid agency and provided appeal rights. Supportive Living Facility staff would assist the person with relocation assistance to another program or setting of the individual's choice.

Department supervisory staff would be informed of the error and provided a listing of qualified Department staff in their region. Continued completion by unqualified staff could result in staff administrative action as appropriate.

The same processes are followed for the dementia program and participants enrolled with a MCO.

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).

At the time of the initial level of care evaluation, all potential waiver participants (or their designated representatives) are informed of feasible service options for either institutional care or waiver services. The Illinois Department on Aging Choices for Care Assessment Form is used for this purpose. Section C., Service Selection and Applicant/Client Certification states, "I have been advised that I may choose community-based services, supportive living facility services or nursing facility placement. I understand that I have the right to change my mind at any time." Services listed are: The Department on Aging's Community Care Program waiver, Department of Human Services waiver for persons with physical disabilities, the Supportive Living Program waiver or nursing facility placement. The participant indicates their service option choice with a check mark and signs his/her name. The Department on Aging's local Case Coordination Units, Department of Human Services, Division of Rehabilitation Services staff and Medicaid agency staff are responsible for the completion of this form.

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

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.

Copies of the Illinois Department on Aging Choices for Care Assessment Form are kept by local Case Coordination Units, caseworkers of the Department of Human Services, Division of Rehabilitation Services and Medicaid agency staff (in cases of private pay residents converting to the waiver). The Medicaid agency maintains copies of forms for private pay residents converting to the waiver.

For participants enrolled in a MCO, the Plans will maintain the Freedom of Choice forms.

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):
Providers of the Supportive Living Program waiver serving Limited English Proficient (LEP) persons are required take steps to ensure equal access to services for these participants. Acceptable practices include: hiring bi-lingual staff, hiring or contracting with interpreters, engaging community volunteers who are bilingual or hiring staff proficient in American Sign Language and translating written documents.

For participants enrolled in a MCO, the Plan shall make all written materials distributed to English speaking enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the Medicaid agency. 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 Plans' written materials must be available in that language as well as 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		
Other Service	Assisted Living		

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:
Assisted Living

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Personal care and supportive services that are furnished to waiver participants who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance. Additionally, medication administration, intermittent nursing services and periodic nursing evauluations are provided. Transportation for activities must be supplied, as well as arrangement for transportation to scheduled medical appointments. Additionally, Personal Emergency Response Systems (PERS) are required in participant apartments and facility common areas. The system is connected to a supportive living facility's emergency call system staffed by nursing and response personnel. Other services include: well-being checks, laundry, housekeeping, three meals/day, snacks, maintenance, assistance with shopping and assistance with access to the larger community. Services that are provided by third parties must be coordinated with the supportive living provider.

Case managment services are provided to assist participants in gaining access to needed waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24-hour skilled care. Nursing services required in the Supportive Living Program include: assessments, service plan development/approval and implementation, health promotion or disease prevention counseling and teaching self-care, medication set-up and medication administration. The use of home health services are also allowed in supportive living facilities, as ordered by a physician, but is not a required service. SLF staff are expected to coordinate care and services with home health care providers. This includes among other skilled services, wound care and physical and occupational therapy. Supportive living facilities must assist participants with obtaining such services.

Access to the larger community is achieved through scheduled activities and assistance with individual preferences with regard to community involvement. Activities in the larger community may include volunteer/charity opportunities, musical presentations, religious programs, sporting events, shopping, cultural destinations and outdoor activities, like fishing. Additionally, community members are invited to participate at the facility. Medical professionals provide information on health and wellness, childrens' groups provide music and social interaction and faith-based groups are also common visitors. Opportunities for community involvement are are communicated to participants both in writing through activity calendars and newsletters, as well as verbally.

All assisted living services are provided by employees of the supportive living facility. Staff provide individualized participant services based on the comprehensive assessment and a participant's preferences as determined through the service planning process. All participants are entitled to receive all of the services provided by the Supportive Living Program. Participants and others of their choosing, such as a designated representative, are involved with the development of the service plan. Participants are able to identify which services they would like to receive and the frequency. The Medicaid agency monitors supportive living facilities to ensure that this individualization occurs and verifies that participant care needs are being met. This monitoring occurs during annual/bi-annual on-site certification reviews and complaint investigations.

Payment for the Supportive Living Program is calculated on a flat daily rate for each day a participant is a resident of a supportive living facility and eligible for Medicaid. Payment is not based on the frequency or type of service provided. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for supportive living facility services is decribed in Appendix I-5.

Participants in the dementia program receive modified waiver service to meet their care needs. Modifed services include: well-being checks three times per day (at least one per shift), at least three scheduled activities per day and alarmed, delayed exit doors. Dementia units also have secured outdoor areas for use by participants.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There are no limits on the amount, frequency or duration of assisted living services being provided to waiver pariticpants. Supportive living facilities must meet the scheduled and unscheduled needs of waiver participants (89 IL Admin. Code, Chap. I, Section 146.230 a). Payment is not made for 24-hour skilled care.

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	Supportive Living Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:
Agency
Provider Type:
Supportive Living Facility
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Supportive living facilities (SLF) are certified by the Medicaid agency. A wide range of factors are examined for SLF providers, such as: financial stability, business experience, knowledge and experience in working with the elderly and people with physical disabilities, record of non-compliance with other state programs and property site control. Certification occurs initially when an SLF becomes operational and can admit waiver participants. It continues on an annual basis through an on-site review process. Initial certification by the Medicaid agency involves the review and approval of resident contracts, facility policies and procedures, emergency plans and quality assurance plans. Additionally, an on-site visit allows for the examination of approved local inspections, as well as the identification of compliance with required structural components, facility maintenance and cleanliness, working building systems, staff background checks, qualifications and training. Final certification requires a review of waiver participant records. An annual certification review combining the components of the initial and final certification processes is conducted at each SLF. Annual reviews determine if providers are in compliance with program requirements.
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
The Medicaid agency.
Frequency of Verification:
The Medicaid agency verifies provider qualifications at the time of initial certification and during annual on-site certification reviews.

Appendix C: Participant Services

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

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

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

As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

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

Case management responsibilities are shared by the Medicaid agency and supportive living facilities (SLF). Each entity has a specific role and duties. SLF staff are required to complete scheduled assessments initially, quarterly and annually. Assessments are also performed if a resident experiences a significant change in condition. SLFs must develop and implement individualized service plans based on participants' needs and preferences identified in the assessment. Service plans are required to be revised when a change in condition occurs and reviewed in conjuction with the required quarterly and annual assessments. Additionally, SLFs must provide assistance with arranging for and coordinating outside services for waiver participants. Examples include: home health services and physician visits. Ancillary services are another case management component supplied by SLFs. Staff must arrange transportation for waiver participants and offer help with activities like shopping, if a participant needs assistance.

The Medicaid agency performs case management services by conducting annual level of care determinations for all waiver participants, review of participant assessments and service plans, addressing problems in service provision, monitoring the implementaion of services plans, monitoring resident health and safety and determining cost neutrality.

In addition to level of care reviews, the Medicaid agency monitors and provides oversight for SLF case management functions. During annual on-site reviews, records of sample of waiver participants are reviewed. The Medicaid agency verifies that assessments were done timely and completed accurately and thoroughly. Service plans must be individualized and contain all of the participant's needs and preferences. This includes any outside services that are being provided. Progress notes, physicians' orders and other documentation contained in the record are also used to verify case management services. Resident interviews are conducted, too.

For participants enrolled in a MCO, case management for overall health care, including waiver services, will be the responsibility of the Plans.

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 Illinois Health Care Worker Background Check Act [225 ILCS 46] (HCWBC Act) requires employees of long term care facilities with duties that involve or may involve contact with waiver participants, or access to the living quarters or the financial, medical or personal records of the participants, to undergo a criminal

background check. 89 IL Admin. Code, Chap. I, Section 146.235 (l) of the Supportive Living Program Rules states, "The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check". Facilities are required to check the Health Care Worker Registry and perform criminal background checks in accordance with the HCWBC Act.

The HCWBC Act requires fingerprint background checks to be completed to identify disqualifying convictions in the State of Illinois. There is no time limit on the background check; any crime committed as an adult is included. Additionally, SLFs must check several sex offender and other criminal registries for new employees. Prior to beginning employment, all unlicensed staff must be checked against the Health Care Worker Registry (Registry), which is maintained by the Illinois Department of Public Health. The Registry identifies if an individual has any disqualifying convictions that would prohibit them from working in a health care setting as defined in the HCWBC Act. If an individual is not listed on the Registry, he or she must go to a State contracted vendor to have their fingerprints collected. The fingerprints are then forwarded to the Illinois State Police. The Illinois State Police updates the Registry and employers are notified of the results within 24-48 hours. If an individual is convicted of a disqualifying offense after they are hired, the Illinois State Police updates the Registry and the employer is notified within 24-48 hours. Additionally, certified nurse aides are fingerprinted and added to the Registry as part of their certification.

Licensed staff employed by the facility, including nurses and dieticians, must have proof of current licensure in the State of Illinois. Background checks for these individuals occur at the time of licensure. Supportive living facilities must maintain a copy of the current license for all licensed staff.

Annual on-site certification reviews are performed by the Medicaid agency for each supportive living facility. Facilities in the dementia program receive bi-annual on-site certification reviews. The review includes verifying documentation of Registry and criminal background checks for 100% of employees hired since the previous review. This includes verifying termination of any individuals with disqualifying convictions. Compliance with the HCWBC Act can also be reviewed during on-site complaint investigations.

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):

A Health Care Worker Registry is maintained by the Illinois Department of Public Health in accordance with the Health Care Worker Background Check Act [225 ILCS 46]. The Illinois Department of Financial and Professional Regulation maintains a listing of licensed nurses and dieticians, including any disciplinary actions.

In accordance with the Health Care Worker Background Check Act [225 ILCS 46], all unlicensed staff who have access to waiver participants, their apartments or their financial or medical records must be checked against the Department of Public Health's Registry prior to starting employment. If a record indicates a fingerprint background check has not been completed, the potential employee must have one completed. Once results are received, the information is forwarded electronically to the SLF and the Registry is automatically updated. If a required Registry check reveals a potential employee has a disqualifying criminal conviction and has not received a waiver from the Illinois Department of Public Health, he/she cannot be employed by the SLF.

All licensed staff must have a current license in the State of Illinois.

Annual on-site certification reviews performed by the Medicaid agency at each supportive living facility

includes examining documentation of registry checks and active licenses for employees hired since the previous review. This is done bi-annually at dementia program facilities.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

89 IL Admin. Code, Chap. I, Section 146.210 outlines structural requirements for supportive living facilities (SLF), that insure a home-like setting for waiver participants. For instance, minimum square footage requirements for apartments insure residents have comfortable living spaces. Each apartment must have a private bath, living, sleeping and cooking and dining areas. Additionally, each apartment must have a door that locks from the inside and individually controlled heating and cooling systems. Participant kitchen areas must include a refrigerator, sink, stove or microwave for cooking and an area for dining. There must also be wiring for telephone and access to cable television or a master antenna. Participants are free to decorate their apartments to reflect their individual taste and style. Additionally, all residents have their own private apartment unless they choose to share a double occupancy unit.

Common areas are also required in supportive livng faciltiies to encourage and support participant socialization. Common areas may include: private dining rooms, libraries, computer rooms, outside garden/patio areas, family rooms and chapels. Resident laundry rooms are required as well so that waiver participants may do their own laundry if they choose. Common areas must be available for participants to use at any time.

Particpants are allowed to come and go from the supportive facility at will. Note the dementia program has alarmed, delayed exit doors. Please see Appendix G. 2. Restrictive Interventions for more information. Additionally, participants are allowed visitors of their choosing at any time.

Access to the larger community is provided in a supportive living facility. Some facilities have their own transportation available and others make arrangements through community senior groups, public transportation or hire a private transportation company. Shopping trips are arranged at least weekly. Examples of other activities that provide an opportunity for community access outside of the supportive living facility include: musical events, religious services, educational opportunities, charity/volunteer opportunities, sporting events, shopping, museum trips, scenic drives and outdoor activities such as fishing. Waiver participants are encouraged to provide input regarding arranged community activities based on their preferences. Supportive living facility staff also encourage individual participant community participation, such as volunteering or taking college classes. The required comprehensive resident assessment also includes a section to identify a resident's individual interests.

Additionally, community members are invited into the facility as part of scheduled activities. Medical professionals provide information on health and wellness and children's groups provide musical entertainment and social interaction. Faith-based groups are also common visitors.

Opportunities for community involvement are communicated to participants both in writing through activity calendars and newsletters, as well as verbally by staff.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Assisted Living	

Facility Capacity Limit:

300

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

The Medicaid agency allows individual facilities to determine the acuity level they want to serve and establish staffing accordingly to meet the scheduled and unscheduled needs of residents 24 hours per day. A minimum staffing ratio for Certified Nurse Aides (CNA) is required based on the number of participants. Other required staff includes a facility manager, registered nurse, cook, dietician and an activity director. The staffing ratios of one CNA for 1-75 participants, two for 76-150 participants and three for 151 or more, are only minimum requirements. Medicaid agency analysis indicates the average number of full-time employed CNAs at a supportive living facility is 10.5. The average number of full-time employed licensed nurses is 2.3. Personal care services can be provided by either licensed nurses or CNAs. Staffing levels must be adequate to meet participant care needs and provide services timely. The demands for these services will vary throughout the day, with fewer services being required in the evening and overnight hours.

In the dementia program, one CNA or licensed nurse is required to be on-site for every ten residents. A licensed nurse must be available at all times as well. The dementia program also requires a manager, registered nurse, cook, dietician and an activity director.

The Medicaid agency monitors staffing requirements during annual on-site certification reviews (bi-annual for dementia programs). Staffing levels are reviwed along with participant care plans. Additionally, staff schedules can be reviewed, staff may be interviewed and reports from emergency call light systems reviewed to verify timely response. Also, interviews are conducted with a sample of participants to verify their needs are being met as they relate to staffing.

Additionally, anyone may register a complaint regarding staffing issues by contacting the Medicaid agency via a toll-free telephone number, written correspondence or in-person during on-site visits by Medicaid agency staff. The Medicaid agency's toll-free number is displayed on Department issued posters in supportive living facilities. Additionally, the number is included in a resident rights brochure provided to participants at the time of admission. Finally, supportive living facilties are also required to display posters issued by the Long Term Care Ombudsman program that include contact information for that program.

Complaints alleging waiver services are not being provided are investigated by the Medicaid agency to determine if staffing is an issue. Medicaid agency staff performs on-site complaint investigations within seven days of receiving the complaint. The investigation begins within 24 hours if the immediate health and safety of participants is an issue. Additional on-site visits may be performed by Medicaid agency staff to offer guidance and technical assistance, which also provide an opportunity to insure staffing levels meet the needs of waiver participants.

If during an on-site reivew the Medicaid agency determines a facility is not maintaining adequate staffing levels, findings of non-compliance are issued and the facility is required to develop and implement a plan of correction. Medicaid agency staff perform a follow-up visit to determine program compliance. Continued non-compliance can result in sanctions, including termination of the Medicaid provider agreement. The Medicaid agency tracks categories of findings issued during annual/bi-annual certification and complaint activities and has not determined that staffing ratios have been problematic.

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.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

The State does not make payment to relatives/legal guardians for furnishing waiver services.

The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

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

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 Medicaid agency does not limit the type of provider that may apply to the Supportive Living Program (SLP). An extensive, detailed process is utilized by the Medicaid agency to review applications from providers wishing to participate in the SLP. Provider qualifications are published in Department rules (89 IL Adm. Code 146.215) and are located on the Department's website, [http://www.slfillinois.com/assets/146.pdf].

To ensure quality services for waiver participants, the Medicaid agency employs a thorough review process for applicants. Interested providers must submit an application and undergo an in-person interview with Medicaid agency staff. Basic information is collected on the application, such as: provider name, planned facility name, location, number of apartments and proposed number of residents. Other detailed information included in the application process and examined by the Medicaid agency includes:

--financial background and stability
--business experience/background
--knowledge and experience with providing services to the elderly and people with physical disabilities
--operating history with other health care facilities or housing programs
--record of non-compliance with state programs
--knowledge of the requirements of the Supportive Living Program, its purpose and its goals
--strategic plan for the facility
--architectural drawings
--phase one environmental study
--market feasibility

Other state agencies, such as the Department on Aging, Department of Human Services and the Illinois Housing Development Authority may also be consulted during the review process. These agencies offer additional information regarding provider qualifications, service history and market area information.

An internal review of the application occurs simultaneously across several divisions of the Medicaid agency, with the agency's SLP coordinator overseeing distribution, tracking, review and return of the application to the agency's Bureau of Long Term Care for processing. Once this portion of the review is completed, the applicant is contacted to schedule a face-to-face interview. Questions related to experience with providing long term care or similar services or programs, familiarity with the SLP waiver and its services and overall plans for the proposed facility are posed to the applicant.

Once an application is approved to proceed towards certification, the applicant is notified in writing by the Medicaid agency. The Medicaid agency may withdraw approval of a SLP application if the applicant fails to become operational within 24 months after the approval of the application. Applicants are allowed to request extensions to

this operational deadline, though extensions should not exceed 12 months from the original operational deadline.

For MCOs:
In the first year, Plans are required to contract with any willing and qualified supportive living facility waiver provider. The State will institute an "any willing provider" contractual clause that will require Plans to offer contracts to any willing provider that meets quality and credentialing standards. After the initial 12-month contracting period, Plans will be allowed to impose a known quality standard and to terminate contracts with underperforming providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Number/percent of supportive living facility applicants that met certification requirements prior to enrollment with Medicaid. Numerator: Number of supportive living facility applicants that met certification requirements prior to enrollment with Medicaid. Denominator: Total number of supportive living facility applicants.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number/percent of enrolled supportive living facilities that continued to maintain certification annually. Numerator: Number of enrolled supportive living facilities that maintain certification annually. Denominator: Total number of enrolled supportive living facilities receiving annual certification reviews.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information

on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Only licensed providers; no need for measures for Sub-assurance B.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Not applicable. See performance measure explanation.

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: N/A	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify: N/A
	Other Specify: N/A	

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: N/A	**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: N/A

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:
Number/percent of certified supportive living facilities that offer training as required by policy. Numerator: Number of supportive living facilities that offered training as required by Department policy. Denominator: Total number of supportive living facilities.

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

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:
Number/percent of certified dementia program supportive living facilities that offer training as required by policy. Numerator: Number of certified dementia program supportive living facilities that offered training as required by Department policy. Denominator: Total number of dementia program supportive living facilities.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Staff training documentation.

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: Bi-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:

Performance Measure:
Number/percent of MCOs that offer training as required by policy. Num: Number of MCOs that offered training as required by policy. Den: Total number of MCOs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: MCO	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
EQRO 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: EQRO	**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: MCO & EQRO	**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 MCOs, the MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples each MCO. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA will pull the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Medicaid agency is reponsible for insuring individual problems are resolved.

Potential supportive living facilities (SLF) found not to meet requirements for initial certification are given an opportunity to make changes that would allow them to meet qualifications. If program rule requirements are not met, the Department does not enter into a Medicaid provider agreement with the facility.

When SLFs that are already certified and providing waiver services are issued findings of non-compliance, a plan of correction (POC) must be developed to address the problem area(s). The POC must be submitted to the Medicaid agency within fourteen days of receipt of the findings and implemented within 30 days. Medicaid agency staff perform a follow-up on-site review to determine if remediation has occurred. If non-compliance is still identified, the SLf receives a form outlining the current non-compliance areas and is given another 30 days to correct. Continued non-compliance during a 2nd on-site follow up review by Medicaid agency staff results in sanctions, including but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, Medicaid agency staff would assist waiver participants with relocation options, including transferring to another SLF. Persistent non-compliance results in sanctions including, but not limited to mandatory in-

service of staff, a hold on admission of new waiver participants or termination of the Medicaid provider agreement.

If a Medicaid provider agreement was terminated, Department staff would assist waiver participants with identifyng possible relocation options, including transferring to another SLF.

The same procedures are followed for the dementia program.

If a MCO was found to not have completed staff training as required, remediation would occur within 60 days in the form of training being completed. Medicaid agency staff would follow up to verify the required training had been completed.

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.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Resident Service Plan (RSP)

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
Registered nurse, licensed to practice in the State
Licensed practical or vocational nurse, acting within the scope of practice under State law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

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:*

Waiver participants (WP) may choose among supportive living facility (SLF) providers. By selecting a SLF and executing a resident contract (RC), the WP accepts the services (svcs) that the SLF is obligated to provide under the Supportive Living Program (SLP). This includes the development (devel) of the resident service plan (RSP) and the delivery of svcs id'd in the RSP which are required to be supplied by the SLF. Svcs. provided by an outside entity must also be arranged and documented in the RSP. The RC must include info. regarding the svcs. the WP will receive from the SLF that are covered under Medicaid (89 IL Admin. Code, Chap I, Section 146.240(b)(1)). A WP is free to cancel a RC and transfer to another svc. provider or choose to participate in another program at any time.

For svcs. not provided by the waiver, such as physical therapy, a WP may select the provider of his/her choice. Additionally, SLFs are required to assist WPs with obtaining these svcs. (89 IL Admin. Code, Chap I, Section 146.230(j)(2)). A WP right of the SLP requires SLFs to inform WPs of rights in conjunction with with any contracted housing and svcs. (89 IL Admin. Code, Chap I, Section 146.250(e)(2)). WPs also have the right to arrange and receive non-Medicaid svcs. (89 IL Admin. Code, Chap I, Section 146.250(e)(7)). The RSP must include coordination and inclusion of svcs. being delivered to a WP by an outside entity (89 IL Admin. Code, Chap I, Section 146.245(d)), as well as any svcs. the WP chooses to decline(89 IL Admin. Code, Chap I, Section 146.250(e)(6)). Providers cannot maintain SLF housing and svcs. in combination with home health, home care, nursing home, hospital, residential care setting, congregate care setting or other type of residence or svc. agency unless those settings and svcs. are licensed, maintained and operated as separate and distinct entities (89 IL Admin. Code, Chap I, Section 146.215(i)). The MA verifies distinction of svcs. annually.

WPs have the right and are encouraged to participate in the devel. of their RSP (89 IL Admin. Code, Chap I, Sections 146.245(d) and 146.250(e)(16)). WPs may also include anyone of their choice to be involved (89 IL Admin. Code, Chap I, Section 146.245(d)). Another right related to a WP's RSP is the option to refuse svcs., so long as others are not harmed by the refusal (89 IL Admin. Code, Chap I, Section 146.250(e)(6)). The SLF must explain the potential consequences to the WP and/or his/her designated representative (rep) and include the refusal in the RSP.

A registered nurse (RN) is responsible for the devel. of the RSP (89 IL Admin. Code, Chap I, Section 146.245 (d)). As a requirement of licensure, the RN must have completed a state approved educational course, which includes patient care planning. Additionally, staff of the MA provide informal, on-site training (trng) during

pre-certification reviews of SLFs and at anytime a SLF requests technical assistance, or monitoring indicates a need. Formal curriculum trng has been provided at joint SLF and MA staff trng. The RN may also provide other SLF waiver svcs. In addition to the RSP, the RN is responsible for the initial assessment (assess)(a licensed practical nurse may also complete), comprehensive resident assess., and quarterly evaluations (89 IL Admin. Code, Chap I, Section 146.245(b),(c) and (e)). Other nursing svcs. include: medication administration, medication set-up, episodic and intermittent health promotion or disease prevention (89 IL Admin. Code, Chap I, Section 146.230 b 1-4). Nursing svcs. must be provided in accordance with the Nursing and Advanced Practice Nursing Act [225 ILCS 65] (89 IL Admin. Code, Chap I, Section 146.230(b)(5)).

The MA provides ovesight of the RSP devel. process and delivery of svcs. by reviewing 100% of new WPs' records and a representative sample of continuing WPs' records annually. RSPs are among the documents examined for timeliness, thoroughness and accuracy, as well as signatures of the licensed nurse and waiver partic. A review of the WP's comprehensive assess. is compared to the RSP to ensure all identified needs are included in the RSP. Additional documentation reviewed may include MD orders, nursing notes and medication orders. The RSP must identify the svcs. that are needed, who will provide the svcs, the frequency and the expected outcome. Any svcs. that are refused by the WP must also be noted.

These requirements also apply to WP in the dementia program. 100% of dementia program WPs' records are reviewed bi-annually.

For WP enrolled in an MCO, the MCO case management team reviews the comprehensive assess. and RSP to verify that all the WP's needs are identified and included in the RSP. The MCO works with the SLF staff to incorporate any changes to the assess. and/or RSP. The MA is responsible for monitoring program compliance for the comprehensive assess. and RSP for WPs enrolled in a MCO. The MCO assists the partic. with arranging for and coordinating outside svcs. These svcs. are communicated to SLF staff for inclusion in the RSP.

Additionally, for WPs enrolled in an MCO, the Plans' case management team completes an assess. to elicit comprehensive information from the WP. The assessments aids in the development of an overall health and support service plan that includes community health svcs., along with the waiver svcs. identified in the RSP developed by the SLF. The components in the assessment used by the Plans include but are not limited to cognitive/emotional, ADLs, IADLs, behavioral health, medication, living supports, environmental conditions and health care information. WPs and their designated rep. are involved in the development of the service plan. Through the assessment and care planning process, the WP's goals and the strengths and barriers to achieving these goals are identified.

The 89 IL Adm Code for the SLP can be accessed at [http://www.slfillinois.com/assets/146.pdf]

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A written resident contract/lease agreement that includes information regarding SLP serivces must be entered into by each waiver participant (89 IL Admin. Code, Chap I, Section 146.240(b)(1) "The resident contract shall include, but not be limited to, the following: Information regarding SLF services the resident will receive that are covered under the Medical Assistance Program"). This contract is signed prior to the time of admission, thus in advance of the development of the RSP. The contract provides the participant and/or his representative with information regarding the services that are available throught the SLP waiver. The Medicaid agency must review and approve all resident contracts. This includes verifying available waiver services are identified in the contract.

A list of waiver participant rights, established by the Medicaid agency, must be provided to each participant with the resident contract (89 IL Admin. Code, Chap I, Section 146.240(b)(7) "The resident contract shall include, but not be limited to, the following: A list of the resident rights as stated in Section 146.250"). Among these is the right to all housing and services for which he or she has contracted and paid (89 IL Admin. Code, Chap I, Section 146.250(e)(2) " All housing and services for which he or she has contracted and paid"). Additionally, it is the right of a waiver participant to be involved in the development, implementation and review of his/her service plan (89 IL Admin. Code, Chap I, Section 146.250(e)(16) "Each resident shall have the right to: Participate in the development, implementation and review of his or her service plans).

SLP requirements also ensure that limited English speaking participants have the opportunity for meaningful communication that allows for equal access to benefits and services (89 IL Admin. Code, Chap I, Section 146.215(n) "The SLF shall ensure that limited English speaking residents have meaningful and equal access to benefits and

services"), including information regarding available services, resident rights and the development of their RSP.

Participant rights established by the Medicaid agency give the participant the right to make and act upon decisions; participate in the development of the RSP; designate or accept a representative to act on the participant's behalf (89 IL Admin. Code, Chap I, Section 146.250(e)(3), "Have his or her records kept confidential and released only with his or her consent or in accordance with applicable law" (15) "Make and act upon decisions (except those decisions delegated to a legal guardian) so long as the health, safety and well-being of others are not endangered by his or her actions", (16) "Participate in the development, implementation and review of his or her service plans", and (19) "Designate or accept a representative to act on his or her behalf"). The RSP form requires the participant's signature and/or his/her representative, if applicable.

All of the above also applies to participants in the dementia program and those enrolled in an MCO.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The resident service plan (RSP) is one of the key tools for service delivery to waiver participants. The RSP is individualized and capsulates the needs and preferences of each participant. Its development is the result of collaboration from the participant, representatives of his/her choice, licensed nursing staff, direct care staff, physicians and outside agencies providing non-waiver services. Each provides valuable input that forms the foundation of the RSP. The RSP is not a static tool, but is always changing to reflect the current needs and preferences of the participant. The participant's service plan outlines the individual needs and preferences of the participant. Needed services that fall within the requirements of the waiver are provided by staff of the supporitve living facility. Waiver participants are assisted by supportive living staff with arranging outside services available through other entities. These services must be included in the participant's service plan. The supportive living facility's registered nursing staff is responsible for coordination of care for waiver and non-waiver services.

(a) Who develops the plan, who participates in the process and the timing of the plan?

The SLF's registered nurse (RN) is responsible for participants' assessments and service plan development. Individuals involved with the completion of the service plan are people who have knowledge of the participant and his/her needs and preferences. This includes the participant, any representative the participant chooses to involve, nursing staff, housekeeper, dietician, activity director and other staff who provide services and have direct contact with the participant.

An initial resident service plan is required within 24 hours of a participant's admission to an SLF (89 IL Admin Code Chap. I, Section 146.245(b) "The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems"). Initial resident service plans are implemented during the period of time between admission and the development and implementation of the resident service Plan (RSP). The RSP is due within 14-21 days of admission and is based on a more comprehensive resident assessment and an observation period. Each RSP is unique and individualized for each waiver participant. The RSP is reviewed and updated in conjunction with required quarterly evaluations and as dictated by changes in a participant's condition, needs or preferences. (89 IL Admin Code Chap. I, Section 146.245(d) "The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences"). RSPs are developed with the waiver participant and his/her designated representative at the SLF and at a time convenient for all parties involved.

The requirements are the same for the dementia program and participants enrolled in an MCO. MCOs also receive a copy of the RSP.

(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.

Standardized Interview:
A standardized interview developed and administered by the SLF that is geared toward the participant's service needs must be done at or before the time of admission (89 IL Admin Code, Chap. I, Section,146.245(a) "The SLF shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy"). It may be used by the SLF to determine if the facility can provide the services the participant needs. The requirement is the same for the dementia program and participants enrolled in an MCO.

Initial Resident Assessment:
An initial resident assessment of the participant and initial resident service plan are completed within 24 hours after admission (89 IL Admin Code, Chap. I, Section 146.245(b) "The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems"). The purpose of the initial resident assessment is to identify and address participant needs/issues that require immediate attention, such as medication assistance or administration. Typically information is obtained from the participant, spouse, family or the participant's representative and medical records. The Resident Assessment Instrument (RAI), which is the comprehensive participant assessment tool described below, may be used or a version thereof may be developed by the SLF for use as the initial assessment. The initial assessment is not intended to take the place of the RAI. These initial documents may be completed by someone other than licensed staff, but must, at minimum, be reviewed and co-signed by either a licensed practical nurse (LPN) or a RN. Because skilled nursing care is not required 24 hours a day in a supportive living facility, in some cases, unlicensed staff may use the initial assessment form to gather information and identify needs and problems. This assessment is reviewed and approved by a LPN or RN within 24 hours of admission. Although the licensed nurse may not physically complete the form, he/she reviews the initial assessment and other documentation, such as physician orders and medication lists to verify the assessment adequately reflects the participant's needs and preferences. The requirements are the same for the dementia program and those enrolled in a MCO. The initial service plan may be built upon to develop the RSP.

Comprehensive Resident Assessment:
The Resident Assessment Instrument (RAI), is a standardized, comprehensive assessment tool required by the Medicaid agency. It is completed for every participant within 7-14 days after admission, annually and in response to a significant change in a participant's condition (89 IL Admin Code, Chap. I, Section 146.245(c) "The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status"). The RAI is designed to capture the participant's strengths, needs, preferences, health status, and risk factors. The RAI assesses a participant's cognitive patterns, communication patterns, vision patterns, mood and behavior patterns, physical functioning, continence, disease diagnosis, health conditions, oral/nutritional status, skin condition, activity pursuit patterns and special treatments. It is completed through means of interview of the participant, participant representative(s), caretakers, and any other appropriate entity, as well as observation. Information documented on the RAI is used to develop the RSP. Development of the RAI is the responsibility of the RN. The requirements are the same for the dementia program and participants enrolled in an MCO.

Quarterly Evaluation:
The quarterly evaluation is a written narrative completed approximately every 92 days from the previous assessment. This evaluation must include information regarding the participant's current status (89 IL Admin Code, Chap. I, Section 146.245(e) "A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed"). As with the other assessments and the development of the service plan, the participant, family, his/her representative and individuals involved with caregiving may contribute to this evaluation. The evaluation form must be signed by the nurse and the participant or designated representative. Any changes noted in the quarterly evaluation related to current services are to be included in the RSP. The quarterly evaluation is the responsibility of the RN. The requirements are the same for the dementia program and those enrolled in an MCO.

Elopement Risk Assessment (dementia program ONLY):
An elopement risk assessment designated by the Medicaid agency must be completed for every dementia program participant prior to admission and quarterly thereafter. The purpose of the assessment is to determine if the participant requires a safety intervention of alarmed, delayed exit doors. This assessment must be completed by a Registered Nurse.

Kitchen Appliance Assessment (dementia program ONLY):
Prior to admission and quarterly thereafter an assessment of the participant's ability to safely operate kitchen appliances in their apartment. This assesment must be completed by a Registered Nurse.

MOCHA or SLUMS Assessment (dementia program ONLY):
Either the Montreal Cognitive Assessment or the St. Louis University Mental Status assessment must be completed for every dementia program participant within 7-14 days of admission. This assessment must be completed by a Registered Nurse. These tools allow memory recall and the ability to follow directions to be assessed.

These assessments apply to residents in a dementia unit who are enrolled in an MCO.

(c) How the participant is informed of the services that are available under the waiver.

The resident contract is required to include information regarding the services available to participants under the waiver. The SLF must ensure the contract is in a language appropriate for the participant (89 IL Admin Code, Chap. I, Section 146.240(f) "The SLF shall ensure that all SLF materials, including the resident contract, shall be in a language appropriate to the resident population"). Facilities are required to submit to the Medicaid agency for approval, prior to use, copies of every type of resident contract, thus ensuring waiver services are included in the contract (146.215(c)(3) "Submit for approval prior to use a model of every type of resident contract to be used by the SLF"). The contract must be signed by the participant or a representative at or prior to occupancy. The requirements are the same for the dementia program and those enrolled in an MCO.

Waiver services include medication management, personal care, housekeeping, laundry, maintenance, meals and snacks, activities, well-being checks, emergency call system and ancillary services, such as assisting with arranging for medical appointments or other services outside of the facility. Additionally, participants enrolled in an MCO (Plan) are informed by the Plan of the covered waiver services at the initial face-to-face visit and annually.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs) and preferences.

By combining information gathered from the RAI and from communication with the participant, designated representative and facility staff, the SLF is able to clearly identify the needs, preferences and goals of each participant and use this information to develop and implement a detailed, individualized RSP.

Every service provided to the participant, whether supplied by the SLF or an outside agency, must be included in the RSP form. It must: (1) identify the problem/need; (2) include a description of the service/assistance provided for each problem or need, state the frequency and duration of services to be provided and who will supply the service; (3) state the expected outcomes of the service.

The plan development process ensures the identification of participant needs, preferences and goals by assessing the individual in a timely manner; using qualified staff to complete and monitor the assessment process and service plan, and by involving the participant and his/her representative(s), and other individuals knowledgeable of the participant's needs and preferences.

The requirements are the same for the dementia program and those enrolled in an MCO. The MCO also receives a copy of the RSP for review.

(e) How waiver and other services are coordinated.

The RSP must include the coordination and inclusion of services being delivered to a participant by an outside entity (89 IL Admin Code, Chap. I, Section 146.245(d) "This includes coordination and inclusion of services being delivered to a resident by an outside entity"). The coordination of waiver and other services are accomplished in a variety of ways, including: during the completion of required assessments, communication at any time between the participant and SLF staff identifying a new need or change in service. Whenever and however the information is learned, it must be incorporated into the RSP.

After a participant's RSP is developed, information related to providing services is shared with relevant SLF staff so that they may implement the services detailed in the plan. For instance, certified nursing assistants may refer to RSPs to obtain information regarding providing assistance with ADLs. Licensed nursing staff can use the RSP to include the resident in the facility medication management plan. Dietary staff may use RSP information to provide any necessary therapeutic diets. Activity staff may use it to identify when a resident may need encouragement to participate in activities. The SLF's RN and management staff are responsible for communicating with other staff regarding the implementation of the RSP for each participant. The SLF's RN is responsible for insuring that the participant's service plan is being implemented appropriately. CNAs and dieticians may also assist in implementing the service plan.

The same is true for the dementia program and those enrolled in an MCO. For those enrolled in an MCO, MCO staff assist with the arrangement and coordination of outside servies. The MCO and SLF nursing staff work closely to insure all of the participant's needs are being met and services coordinated.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the

plan.

The RSP must identify who will provide each service (89 IL Admin Code, Chap. I, Section 146.245(d) "The service plan shall include...whether the services will be provided by licensed or unlicensed staff"). During the development process of an RSP, the appropriate individuals are notified regarding their responsibilities in providing specific services to the participant. The timeframes that are established for achieving goals are used by the RN to monitor the effectiveness of the approaches used to reach the goals. The SLF's RN is responsible for assigning responsibilities to implement the plan and also to monitor. The same is true for the dementia program and those enrolled in an MCO. MCO staff also review the RSP to make sure the participant is receiving all of the services they need.

(g) How and when the plan is updated, including when the participant's needs change.

At a minimum, the RSP must be reviewed quarterly. If a participant experiences a significant change in condition, needs or preferences, the RSP must be updated at that time to reflect changes(89 IL Admin Code, Chap. I, Section 146.245 (d) "The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences"). The same is true for the dementia program and those enrolled with an MCO.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks are to be identified during the required formal assessment processes and at any time potential risks arise due to a change in the participant's status. At the time the participant is assessed for a potential risk, the risk must be discussed with him/her, and/or designated representative. The physician may also be included. The service plan should indicate the risk and what will be done to overcome the risk and which staff and/or service provider will be included in overcoming the risk. Should the participant choose to refuse assistance in overcoming the risk, this will be documented on the service plan. For those enrolled in an MCO (Plan), the Plan will be notified.

Resident rights for the Supportive Living Program allow the participant to refuse to participate in any service or activity once the potential consequences of such refusal have been explained to the participant or his/her representative, so long as others are not harmed by the refusal (89 IL Admin. Code, Chap. I, Section 146.250(e)(6) "Each resident shall have the right to: Refuse to receive or participate in any service or activity once the potential consequences of refusal have been explained to the resident and the resident's designated representative, if requested by the resident. Refusal shall be documented in the service plan and reviewed no less than quarterly"). The participant may also ask that the State Long Term Care Ombudsman be present during these discussions. This section also allows the participant to remain in the SLF foregoing recommended or needed services from the SLF or available from others. However, should the participant forgo recommended services, an acknowledgement shall be made that the decision was made against the advice of the SLF or other appropriate entities. 89 IL Admin. Code, Chap. I, Section 146.245(d) requires that these refused services be documented on the service plan ("The service plan shall document any services recommended by the SLF that are refused by the resident").

This process also applies to participants in the dementia program and those enrolled with an MCO.

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.

Waiver participants, including those in the dementia program, may choose among any certified supportive living facility (SLF) providers. Participants enrolled with an MCO may choose any certified SLF provider that contracts with the MCO. Information regarding these providers and services is available through a variety of resources, including the Supportive Living Program website and the Medicaid agency directly. Additionally, the Illinois Department of Human Services Family and Community Resource Center caseworkers, who are responsible for accepting Medicaid applications and determining eligibility, may make referrals. The Illinois Department on Aging and its contracted agencies, including Case Coordination Units that perform Determination of Need Assessments for residents in need of long term care, may provide information regarding the SLP to potential residents and their

families, too.

For participants enrolled in an MCO, the Plan assists the participant in obtaining information about and selecting from among qualified providers of the waiver services. The Plans provide information about the available services and service providers to each participant and answer any questions that arise. The Plan will assist the participant through the provider network supplying provider information relevant to the services selected by the member and available in the service area of their choosing. Participants always have first choice of the provider they select to meet their needs. The Plans will support the participant in selecting a provider to meet their needs if the participant does not a have a preferred provider identified. The Plan maintains a current list of qualified and contracted service providers which is made available to participants upon request. The participant is also educated that the Plan's provider list is available on the Plan's website.

By selecting a facility and executing a resident contract, the participant accepts the services that the facility is obligated to provide under the Supportive Living Program (SLP) waiver. A participant is free to cancel a resident contract and transfer to another service provider or choose to participate in another program at any time. This applies to participants in the dementia program and those enrolled in an MCO as well.

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):

Supportive living facilities must develop resident service plans (RSP)in accordance with Department requirements. (1) The Resident Assessment Instrument must be used to identify needs and health care issues. (2) The resident, the designated representative and relevant health care providers must be involved in the development of the RSP. (3) The RSP must be completed in a Department designated format that identifies the problem/need, a description of the service(s) to be provided to meet the need and the expected outcomes.

The Medicaid agency conducts annual on-site certification reviews at all supportive living facilities (SLF) and bi-annual reviews for facilities in the dementia program. This includes reviews of RSPs for a representative random sample of all continuing waiver participants and 100% of new waiver participants. 100% of dementia program waiver participant records are reviewed. Medicaid agency staff complete an in-depth record review that includes, but is not limited to the RSP, comprehensive resident assessment, quarterly assessments, medication administration records, incident reports and physician orders. This comprehensive review allows Medicaid agency staff to ascertain whether all of the participants' needs and preferences have been identified and are being met through services outlined in the RSP. Medicaid agency staff also determine if assessments and RSPs were completed timely and that any changes in condition were captured.

For the MCOs, the Medicaid agency selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The Medicaid agency uses a proportionate sampling methodology with a 95% confidence level and a 5% margine of error for the MCOs. The methodology will be adjusted when new MCOs are enrolled to ensure proportionate sampling across MCOs.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

Medicaid agency

Operating agency

Case manager

Other

Specify:

For participants enrolled in an MCO, the Plan is also required to maintain waiver service plan forms.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Medicaid agency is responsible for monitoring service plan implementation and the health and welfare of waiver participants, including those in the dementia program. On-site monitoring is performed annually, at a minimum. Participants in the dementia program are reviewed bi-annually.

As a part of this monitoring process, comprehensive record reviews are conducted annually for a random representative sample of continuous waiver participant at all supportive living facilities (SLF) and 100% of new waiver participants. One hundred percent of participants in the dementia program are reviewed bi-annually. This monitoring involves an in-depth record review that includes, but is not limited to: the RSP, comprehensive resident assessment, quarterly assessments, nursing notes, progress notes, medication administration records, incident reports and physician orders. Medicaid agency staff also meet in person with waiver participants included in the random representative sample.

Medicaid agency staff insure participants' comprehensive assessments, which are used in the development of the RSP, are completed within required timeframes, accurately reflect health conditions and service provision and that any significant changes in condition are documented.

The RSP must reflect the needs and preferences identified in the comprehensive assessment, services required by physician's order, services declined by a participant and any services provided by an outside provider. Nursing notes, progress notes, medication administration records and other documents are examined to make sure services are being provided.

The health and safety of waiver particpants is verifed by confirming that all required and preferred services are included in the RSP, that risks are identified and mitigated, participants' physicians are notified and that required Medicaid agency reporting takes place as required by administrative rule.

Medicaid agency staff also document that the RSP is signed by the participant and/or his/her designated representative, indicating their involvement with the development of the RSP and their choice in selecting the SLF to provide required waiver services and/or assist with coordination of outside services. In order to determine if the RSP has been developed accurately and is being fully implemented to meet all of the services needed and preferred by the participant, the Medicaid agency reviews the various documents noted above in the participant record.

This thorough review allows Medicaid agency staff to ascertain whether or not all of the participant's needs and preferences have been identified and are being met through services outlined in the RSP. For instance, if a review of nursing notes indicates a participant has recently fallen several times, Medicaid agency staff expect the RSP to contain information related to fall-prevention services. Additionally, if the participant records contains a physician's order for physical therapy, Medicaid agency staff would check to see if the outside services provided by the outside provider were obtained and included in the RSP.

If a participant experienced a significant change in condition, Medicaid agency staff make sure the change was noted in the comprehensive resident assessment and the RSP as necessary. They also verify that the participant's physician and designated representative were notified as required by administrative rule.

More frequent monitoring of waiver particpants' RSPs and health and safety may occur as a result of complaint investigations. Additional monitoring may also be required in instances when facilities receive repeat investigation findings within a twelve month period. The findings do not have to be related or the same.

Any Administrative Rule violations related to RSP implementation and the health and welfare of residents are cited as findings of non-compliance by the Medicaid agency. The SLF is provided a Response to On-Site Review Findings forms which outlines the rule violations. The SLF must then develop and implement a plan of correction (POC) within 30 days of receipt of the findings. Medicaid agency staff follow up to ensure the POC has been implemented and has corrected the problem. If it has not, another 30 days is allowed and another follow-up visit is conducted. If at this time the facility still has not corrected the non-compliance, sanctions may be issued by the Medicaid agency, including termination of the Medicaid provider agreement. The same process applies for facilities in the dementia program.

For participants enrolled in an MCO, the Plan is also responsible for monitoring service plan implementation, including whether services and supports meet the participants' needs.

The Plans have a process to implement a method of monitoring its staff to include, but not be limited to conducting quarterly case file audits and quarterly reviews checking that service plans are completed with each assessment or in between assessments if members needs have changed, services listed on the service plan and address member's needs identified in the comprehensive resident assessment. The Plans 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 Plan has taken to resolve identified issues. The Plans will provide the Medicaid agency with the results of their discovery, remediation and any systems improvement activities during quarterly quality improvement meetings. Remediation will occur both on an indiviudal and systemic basis.

On an annual basis, the Medicaid agency selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The Medicaid agency uses a proportionate sampling methodology with a 95% confidence level and a 5% margin of error. The methodology will be adjusted when new MCOs are enrolled to ensure proportionate sampling across all MCOs.

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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number/percent of waiver participants' and MCO waiver participants'service plans that address all of their assessed needs and personal goals. Numerator: Number of waiver participants' and MCO waiver participants' service plans that address all of their assessed needs and personal goals. Denominator: Total number of waiver participant and MCO waiver participant service plans reviewed.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports/EQRO 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 = +/-5%
Other Specify: MCO/EQRO	**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: MCO	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
#/% of dementia prog. waiver partic.s' and MCO dementia waiver partic.s'service plans that address all of their assessed needs and personal goals. N: # of dementia prog. waiver partic.s' and MCO dementia waiver partic.s' service plans that address all of their assessed needs and personal goals. D: Total # of dementia prog waiver partic. and MCO dementia waiver partic.s'service plans reviewed.

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports/EQRO 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 = +/-5%
Other Specify: MCO/EQRO	**Annually**	**Stratified** Describe Group:
		Other

	Continuously and 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: MCO	**Annually**
	Continuously and Ongoing
	Other Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number/percent of waiver participants who have service plans completed within 7 days of their comprehensive assessment. Numerator: Number of waiver participants with service plans completed within 7 days of their comprehensive assessment. Denominator: Total number of waiver participant service plans reviewed.

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

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

State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = +/-5
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:
Number/percent of dementia program waiver participants who have a service plan completed within 7 days of their comprehensive assessment. Numerator: Number of dementia program waiver participants with service plans completed within 7 days of their comprehensive assessment. Denominator: Total number of dementia program waiver participant service plans reviewed.

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

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

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

Performance Measure:
Number/percent of waiver partipant service plans updated following an annual assessment. Numerator: Number of waiver participant service plans updated following the annual assessment. Denominator: Total number of waiver participant service plans reviewed that require an annual assessment.

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 = +/-5
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:
Number/percent of waiver participant service plans updated following a significant change(s) in condition. Numerator: Number of waiver partipant service plans updated following a significant change(s) in condition. Denominator: Total number of waiver participant service plans reviewed who experienced a significant change(s) in condition.

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 = +/-5
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:
Number/percent of dementia program waiver participant service plans updated following an annual assessment. Numerator: Number of dementia program waiver participant service plans updated following the annual assessment. Denominator: Total number of dementia program waiver participant service plans reviewed that require an annual assessment.

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

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

	Continuously and Ongoing	**Other** Specify:
	Other Specify: Bi-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:

Performance Measure:
Number/percent of dementia program waiver participant service plans updated following a significant change(s) in condition. Numerator: Number of dementia program waiver participant service plans updated following a significant change (s) in condition. Denominator: Total number of dementia program waiver participant service plans reviewed.

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

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

Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify: Bi-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:

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:
Number/percent of waiver participants with written documentation of services provided according to the service plan. Numerator: Number of waiver

participants with written documentation of services provided according to the service plan. Denominator: Total number of waiver participant 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 = +/-5
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:
Number/percent of dementia program waiver participants with written documentation of services provided according to the service plan. Numerator: Number of dementia program waiver participants with written documentation of services provided according to the service plan. Denominator: Total number of dementia program waiver participant records reviwed.

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

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

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:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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:
Number/percent of waiver participants with signatures on their service plan which attests to their choice of waiver services instead of institutional care. Numerator: Number of waiver participants with signatures on their service plan attesting their choice of waiver services. Denominator: Total number of waiver participant service plans reviewed.

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

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

Specify:		**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:
Number/percent of new waiver particiants with a signed resident contract with the SLF attesting their choice of waiver provider. Numerator: Number of new waiver participants with a signed resident contract with the SLF attesting their choice of waiver provider. Denominator: Total number of new waiver participants.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number/percent of dementia program waiver participants with signatures on their service plan which attests to their choice of waiver services instead of institutional care. Numerator: Number of dementia program waiver participants with signatures on their service plan attesting their choice of waiver services. Denomin: Total number of dementia program waiver participant service plans reviewed.

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

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

Performance Measure:
Number/percent of dementia program waiver participants with a signed resident contract with the SLF attesting their choice of waiver provider. Numerator:

Number of new dementia program waiver participants with a signed resident contract with the SLF attesting their choice of waiver provider. Denominator: Total number of new dementia program waiver participants.

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

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

Data Aggregation and Analysis:

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

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

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 samples for the record reivews to verify that all of a participant's assessed needs and goals are included in the service plan will include separate samples for ICP and non-ICP enrollees. The samples for ICP enrollees with be proportionate among the MCOs. These samples, like the ones for non-ICP residents, will be less than 100% review, but will have a 95% confidence level and a 5% margin of error. This applies to dementia program residents as well.

In addition, the EQRO and MCO will review files using the same sampling methodology (95%, +/-5%) referenced above to determine if MCO staff verified the service plan included all of the participant's assessed needs and goals.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The state Medicaid agency is reponsible for insuring individual problems are resolved.

Incomplete service plans:
If a waiver participant's service plan does not address all of his/her assessed needs, the service plan must be revised. This remediation is verified by Medicaid agency staff.

Untimely Service Plans:
When a waiver paricipant does not have a current service plan, one must be developed and implemented. Medicaid agency staff verify this remediation. For missing service plans and completed but untimly service plans, the Medicaid agency may issue findings of non-compliance. See procedure outlined at the end of this section.

Service Plans Following Annual Assessment:
If a waiver participant's service plan is not updated following the required annual assessment, this must occur once identified. Medicaid agency staff verify this remediation.

Significant Changes in Condition:
If a waiver participant's service plan is not updated following a significant change in condition requiring new services, it would have to be updated once discovered. Additionally, the SLF would have to provide or arrange for any new services as the result of a change in condition. Medicaid agency staff verify this remediation occurs.

Documentation of Services:
If Medicaid agency staff cannot find evidence of services identified in the waiver participant's service plan being provided, the plan would have to be updated to accurately reflect the services that were needed. The facility would then need to document services were provided. Medicaid agency staff verify this remediation occurs.

Signed Service Plan:
When a waiver participant's signature, or their designated representative's, is not included on the ervice plan, the plan must be reviewed with the waiver participant. After the review, the waiver participant is given the choice of accepting the waiver services outlined in the plan by signing the service plan. Medicaid agency staff verify this remediation occurrs.

Signed Resident Contract:
When a waiver participant's signature, or their designated representative's, is not on the resident contract, the

contract must be reviewed with the waiver participant. After the review, the waiver participant is given the choice of accepting the provider for waiver services which is indicated by signing the contract. Medicaid agency staff verify this remediation occurrs.

In all cases of individual non-compliance outlined above, including in the dementia program, the Medicaid agency may issue findings of non-compliance to the supportive living facility (SLF) for individual problems when discovered. The SLF is presented with a form outlining the areas of non-compliance. A plan of correction (POC) must be submitted to the Medicaid agency within fourteen days of receiving the form. The plan must be implemented within 30 days. Medicaid agency staff perform a follow-up on-site review to determine if remediation has occurred. If non-compliance is still identified, the SLF receives a form outlining the current non-compliance areas and is given another 30 days to correct. Continued non-compliance during a 2nd on-site follow-up review by Medicaid agency staff results in sanctions, including but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, Medicaid agency staff would assist waiver participants with relocation options, including transferring to another SLF. In the case of services not being provided, Medicaid reimbursement could be recovered.

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:

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.

The State of Illinois assures that each person whose claim for assistance is denied or not acted upon promptly is provided an opportunity for a fair hearing. Applicants and/or clients have the right to appeal any action, such as denial or termination of services or reductions in service levels. Illinois assures an opportunity for a fair hearing under 42 CFR Part 431, Subpart E, to waiver participants and potential waiver participants who are not given the choice of supportive living services as an alternative to nursing facility services or who are denied the services of their choice. This can occur as a result of not being determined eligible for supporive living program waiver services or receiving a notice of involuntary discharge from a supportive living facility (SLF).

Waiver participants or their designated representative are informed of the appeal process in writing at the time of the denial of services. Furthermore, resident contracts for SLFs must contain information regarding the involuntary discharge process, including the participant's right to appeal (89 IL Admin. Code, Chapt. I, Section 146.240(b)(5) "The resident contract shall include, but not be limited to, the following: The conditions under which the resident contract may be terminated by either party"). All resident contracts must be approved by the Medicaid agency, which insures appeal information is included.

Eligibility for SLP waiver services:
Prior to admission, all potential waiver participants, including those in the dementia program, must undergo a preadmission screening, including a Determination of Need (DON) assessment. Potential participants must meet a minimum score required for enrollment in the state's Medicaid-funded long term care programs (either institutional or home and community -based waivers), including the Supportive Living Program. If a potential resident disagrees with the preadmission screening results, he/she may submit a request for an appeal to the Medicaid agency. An appeal form and self-addressed postage paid envelope is provided to the potential resident by the supportive living faciltiy. The Medicaid agency is responsible for maintaining the appeal documents and also reviews appeals.

Level of Care Determinations (LOCD) are performed annually for each waiver participant, including those in the dementia program, by the Medicaid agency. If a participant is found to no longer meet the required minimum level of care, a Case Action Notice form is issued by the Medicaid agency. This form contains the reason(s) why the participant is no longer eligible for the program. Additionally, a Notice of Appeal form is supplied to the participant that contains a phone number to contact the Medicaid agency to request assistance with filing the appeal. The Medicaid agency is responsible for maintaining the Case Action Notice Form and also reviews appeals.

Involuntary Discharge From a Supportive Living Facility:
Supportive living facilities must always provide written involuntary discharge notices to waiver participants ((89 IL Admin. Code, Chapt. I, Section 146.255 (b) "The SLF shall provide a resident with a 30-day written notice of proposed involuntary discharge unless such a delay might jeopardize the health, safety, and well-being of the resident or others"). A 30 day notice is required, expect in instances when participants are a danger to themselves or others, or when the participant's physical or mental health care needs require discharge sooner for their health and safety (89 IL Admin. Code, Chapt. I, Section 146.255 (b) and (e) "The 30-day notice required under subsection (b) of this Section shall not apply in either of the following instances; however, a notice and right to appeal information must still be provided when an immediate discharge is required: 1) When an emergency discharge is mandated by the resident's health care or mental health needs as documented in the resident record. The SLF may consult with the attending physician for additional support on the emergency discharge. 2) When the discharge is mandated to ensure the physical safety of the resident and other residents as documented in the resident record"). A 30 day written notice of discharge can be issued by a supportive living facility when: a participant breaches the resident contract, the facility has had its certification terminated, suspended, or not renewed by the state Medicaid agency, the facility cannot meet the participant's needs with the required support services or when a participant has received proper notice of failure to pay the facility for room and board and/or services. In the instance of non-payment, the participant has the right to make full payment up to the date that the discharge is to be made and then shall have the right to remain in the facility.

The Notice of Involuntary Discharge form must be completed by the SLF and given to the participant. The form includes

the reason(s) for discharge, information for filing an appeal and a phone number for the Medicaid agency to request assistance with filing the appeal (89 IL Admin. Code, Chapt. I, Section 146.255(b)) The SLF is required to supply a self-addressed, stamped envelope with the appeal form (89 IL Admin. Code, Chapt. I, Section 146.255(b)(4) "A hearing request form, together with a postage paid, preaddressed envelope to the Department"). If an appeal is filed, the discharge is stayed until the hearing decision is rendered. The rule states that he/she may remain in the facility until the 10th day after receipt of the Medicaid agency's hearing decision, unless the participant is a danger to himself or others. SLFs must maintain Notice of Involuntary Discharge forms. The supportive living facility is responsible for maintaining the Notice of Involuntary Discharge form and right to appeal information. The Medicaid agency is responsible for conducting the hearing.

Illinois State Long Term Care Ombudsman Program can assist residents with filing an appeal for any denial or reduction in services.

The above requirements apply to participants in the dementia program and enrolled in an MCO as well.

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:

The Medicaid agency is responsible for operating the Supportive Living Program complaint system.

Each MCO is required to establish and maintain a procedure for reviewing grievances (any expression of dissatisfaction about any matter other than an action or provider violation of administrative rule requirements) registered by enrollees. All grievances are registered initially with the MCO and may later be appealed to the Department through the Fair Hearing process. Enrollees must exhaust the MCO's grievanace process before requesing a Fair Hearing.

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).

Complaints related to supportive living facilities (SLF) may be registered by anyone. Complaints are received from waiver participants, friends and family, employees of facilities and State Long Term Care Ombudsman. Individuals may register a complaint anonymously. The Medicaid agency receives complaints directly via a toll-free telephone

number, e-mail, written correspondence and in-person during on-site visits by Medicaid agency staff. There is no timeline for registering complaints or restrictions for complaint issues. Additionally, all complaints are kept confidential.

When the Medicaid agency receives a complaint involving a possible administrative rule violation, a SLF Complaint Referral Notice is completed and forwarded to regional Medicaid agency staff. This form contains specifics about the complaint, including waiver participants and staff involved, the nature of the complaint(s) and dates of incidents. For confidentiality, resident and staff names are not identified on the form itself, but are provided to regional Medicaid agency staff on an attached key. Medicaid agency staff must begin an investigation within seven days of receipt of the complaint. If a complaint involves immediate participant health and safety, regional staff are directed to investigate immediately. Medicaid agency employees are also mandated reporters. This status requires them to report suspected abuse or neglect to local law enforcement.

Complaint investigations are performed on-site at the SLF. Investigations may involve interviews with waiver participants and staff, review of participant records and employee records, a tour of the facility and observation of staff providing services. Substantiated administrative rule violations are reported in writing to the SLF on the Response to On-Site Review Findings form. The SLF must develop and implement a plan of correction within 30 days of receipt of the findings. Medicaid agency staff must perform an on-site follow-up to verify remediation has occurred and that the facility is in compliance with administrative rules. Persistent non-compliance in making corrections results in sanctions, including, but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, Department staff would assist waiver participants in identifying possible relocation options, including transferring to another SLF.

The State Long Term Care Ombudsman also receive a copy of the SLF Complaint Referral Notice. Ombudsman can choose to attend the on-site review with Medicaid agency staff, and/or perform their own investigation. Additionally, the Medicaid agency's final investigation report is also shared with the ombudsman.

Concerns regarding denial of Medicaid eligibility and involuntary discharges are not handled by the complaint investigation process. In both of these instances, waiver participants are provided an opportunity to file for a fair hearing. The fair hearing process and the complaint system process are separate and independent.

The above also applies to participants in the dementia program and those enrolled in an MCO.

For participants enrolled in an MCO, applicable grievances shall be registered initially with the Plan and may later be appealed to the Medicaid agency. The Plan's procedures must (i) be submitted to the Medicaid agency in writing and approved in writing by the Medicaid agency; (ii) provide for prompt resolution and (iii) assure the participation of individuals with authority to require corrective action. The Plan must have a Grievance Committee for reviewing grievances registered by its enrollees, and enrollees must be represented on the Grievance Committee. At a minimum, the following elements must be included in the Grievance process:
--An informal system, available internally, to attempt to resolve all grievances;
--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 (including, without limitation, procedures to ensure expedited decision making when an Enrollee's health so neccesitates);
--Formally structured Grievance Committee that is available for enrollees whose grievances cannot be handled informally and are not appropriate for the procedures set up under the Managed Care Reform and Patient Rights Act. All enrollees must be informed that such a process exists. Grievances at this state must be in writing and sent to the Grievance Committee for review;
--The Grievance Committee must have at least one (1) enrollee on the Committee. The Medicaid agency may require that one (1) member of the Grievance Committee be a representative of the Medicaid agency;
--Final decisions under the Managed Care Reform and Patient Rights Act procedures and those of the Grievance Committee may be appealed by the enrollee to the Medicaid agency under its Fair Hearings system;
--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 Medicaid agency quarterly; and
--An enrollee may appoint a guardian, caretaker relative, PCP, WHCP, or other Physician treating the enrollee to represent the enrollee through the Grievance process.

The state has provided that individuals must first avail themselves of the internal grievance and appeals process before accessing the Fair Hearings process. Enrollees are notified of this through the Enrollee Handbook, the Notice of Action, and any appeal letters. Plans also discuss the grievance and appeals process with the Enrollee.

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).

89 Illinois Administrative Code Chapter 1, Section 146.295 defines an emergency as an event, as the result of a mechanical failure or a natural force such a water, wind, fire or loss of electrical power, that poses a threat to the safety and welfare of residents, personnel and others present in the supportive living facility (SLF). Additionally, 89 Illinois Administrative Code Chapter 1, Section 146.305(b) states the SLF manager or employee shall contact local law enforcement authorities immediately when suspected abuse, neglect or financial exploitation involving physical injury, sexual abuse, a crime or death occurs to a resident as the result of action by a staff member, family member, visitor, or another resident. All of these incidents must be reported to the Medicaid agency within 24 hours of the occurence (146.295(l) "Upon the occurrence of an emergency resulting from a mechanical failure or natural force requiring hospital service, police, fire department or coroner, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours after the occurrence" and 146.305(e) "Upon the occurrence of suspect abuse, neglect or financial exploitation that results in contact with local law enforcement, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours after the occurrence"). When a participant is harmed during an emergency (as defined above), the SLF must inform the participant's physcian and the designated representative (89 IL Admin. Code, Chapter I, Sec. 146.245(h) "The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities"). Except in life threatening situations, this notification must take place within 24-hours. Notification by phone is acceptable.

Reports for the incidents outlined above must identify the type of emergency, date(s) it occurred, any outside agencies involved, the names of residents involved, evacuation location(s), number of injuries or deaths, estimate of the extent of damage to the facility, and the facility's response to the emergency/incident. Medicaid agency staff review reports to insure incidents were handled appropriately by facility staff, that the appropriate agencies were contacted (i.e., physician, police or fire) and to determine if any further review is required. Follow up information, such as police investigation documents, employee termination records or coroner reports may also be obtained.

Additionally, Illinois' Mandated Reporter Act (320 ILCS 20)requires healthcare workers, State Long Term Care Ombudsman, SLF staff and Medicaid agency staff to report suspected instances of abuse, neglect and financial exploitation to law enforcement authorities for further investigation. The SLF is expected to cooperate with any outside investigation conducted by law enforcement.

The above also applies to the dementia program and those enrolled in an MCO.

For participants enrolled in an MCO, the Plans will have processes and procedures in place to receive reports of critical incidents. The Plans will comply with the Elder Abuse and Neglect Act (320 ILCS 20/1). The Plans shall have a formal process for reporting incidents that may indicate abuse, neglect or exploitation on an enrollee. The Plans must comply with the Medicaid agency's critical incident reporting requirement and notify the Medicaid

agency of any critical incidents discovered, if this occurs prior to the SLF submitting a report to the Plan and Medicaid agency. If the Plan perceives an immediate threat to the participant's life or safety, the Plan will follow emergency procedures which may include calling 911.

Supportive Living Facilities will be required to submit critical incident reports involving MCO enrollees to the Plans, as well as the Medicaid agency. All incidents will be reported to the compliance officer or designee and entered into the Plan's Critical Incidents report database. If Medicaid agency staff perform an on-site review in response to the critical incident, a summary of the report will be shared with the Plans.

The Plans will provide participants, their family or representatives information about their rights and protections, including how they can safely report an event and receive the necessary intervention and support.

Also, the Plans will assure that HCBS waiver agencies, vendors and workers (including case managers) are well informed of their responsibilities to identify and report all critical incidents. Responsibilities are also reinforced through periodic training.

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

Supportive Living Facilities (SLF) are required to include a listing of resident rights, as detailed in 89 IL Admin. Code, Chapter I, Sec. 146.250(e), in the resident contract (89 IL Admin. Code, Chapter I, Sec. 146.240(b)(7) "The resident contract shall include, but not be limited to, the following: A list of the resident rights as stated in Section 146.250"). Included in these rights are the right to be free from mental, emotional, social and phsycial abuse and neglect and exploitation. Another is the right to be treated at all times with courtesy, respect and full recognition of personal dignity and individuality. Every participant or his/her designated representative must review and sign the resident contract prior to admission. The Medicaid agency reviews SLFs' resident contracts to ensure resident rights information is included.

Additionally, the Medicaid agency requires SLFs to supply all participants with a "Hotline Information and Residents Rights" brochure at the time of admission. This brochure lists all of the rights participants have as residents of an SLF and also offers the toll-free complaint hotline phone number. This brochure has been created and is distributed to SLFs by the Medicaid agency. SLFs must also hang posters of the Medicaid agency's toll-free complaint hotline.

The Medicaid agency requires SLFs to ensure limited English speaking participants have meaningful and equal access to services, including notification of their rights (89 IL Admin. Code, Chapter I, Sec. 146.215(n) "The SLF shall ensure that limited English speaking residents have meaningful and equal access to benefits and services"). This requirement can be met by having printed materials available in Braille and languages other than English, hiring bilingual staff or interpreters, and providing information to participants' representatives.

Additionally, SLFs must encourage families of participants with impairments that limit the participant's decision making ability to arrange to have a responsible party or guardian represent the person's interests (89 IL Admin. Code, Chapter I, Sec. 146.215(o) "The SLF shall encourage families of residents with impairments that limit the resident's decision-making ability to arrange to have a responsible party or guardian represent the resident's interests").

During annual on-site reviews (bi-annual reviews are conducted for dementia program particpants), Medicaid agency staff conduct interviews with waiver participants. A portion of the interview determines if the participant is aware of his/her rights. If a participant is not aware of his/her rights, Medicaid agency staff provide them with a copy of the "Hotline Information and Resident Rights" brochure.

The State Long Term Care Ombudsman Program also distributes printed resident rights information to participants. Additionally, contact information for registering complaints to the ombudsman is also provided.

The above also applies to participants in the dementia program and those enrolled in a MCO.

For participants enrolled in an MCO, the Plan shall train all of the Plan's employees, Affiliated Providers, Affiliates and subcontractors to recognize potential concerns related to abuse and neglect, and on their responsibility to report suspected or alleged abuse or neglect. The Plan's employees who, in good faith, report suspicious or alleged abuse or neglect shall not be subjected to any adverse action from the Plan, its Affiliated Providers, Affiliates or subcontractors.

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 Medicaid agency receives critical incident reports. Participant abuse and neglect, serious injuries that require medical intervention and/or result in hospitalization, criminal vicitimization, death (other than by natural causes), financial exploitation and other incidents or events that involve harm or risk of harm to a participant are reported by SLFs to the Medicaid agency (89 IL Admin. Code, Chapter I, Sec. 146.295(l) "Upon the occurrence of an emergency resulting from a mechanical failure or natural force requiring hospital service, police, fire department or coroner, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours after the occurrence. This includes, but is not limited to, loss of electrical power in excess of an hour, physical injury suffered by residents during a mechanical failure or force of nature, evacuation of residents for any reason, and fire alarm activation that results in an on-site response by the local fire department. It does not include fire department response that is the result of resident cooking mishaps that only cause minimal smoke limited to a resident's apartment or false alarm as determined by the local fire department" and 146.305 (e) "Upon the occurrence of suspect abuse, neglect or financial exploitation that results in contact with local law enforcement, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours after the occurrence. This includes, but is not limited to, suspected abuse of any nature, allegations of theft, elopement of residents or missing residents, and any crime that occurs on facility property"). An incident report must be submitted to the Medicaid agency within 24 hours of the occurence.

The Medicaid agency reviews incident reports and determines if further follow-up is required according to established procedures. All follow-up is conducted by the Medicaid agency. Follow-up may be determined to be necessary by the Medicaid agency if a SLF did not notify the appropriate entites, such as, police, physcian or a participant's emergency contact. A follow-up investigation would also be required in the case of a serious incident, such as the death of participant not related to natural causes. On-site reviews are also conducted in response to extended utility outages to verify that participants are safe and their needs are being met. The Medicaid agency may also investigate if incidents occur repeatedly or show a pattern.

The need for follow-up investigations for critical incidents is determined based on the severity of the incident and the impact on participants, particularly their health and safety. Medicaid agency procedure requires on-site follow-up for incident reports impacting resident health and safety. Examples of such incidents include power outages lasting more than 48 hours when residents are not evacuated, physical damage to an SLF as the result of weather, fire or physical plant malfunction and also resident injury or death resulting from an emergency, such as a fire.

Regional Medicaid agency staff conduct the on-site review within 24 hours of being notified by supervisory Medicaid agency staff, who receive the incident report from the SLF. The review can include examination of the physical structure of the SLF, interviews with participants and staff, participant and facility record reviews related to the incident and also outside reports related to the incident, such as police reports. A preliminary report is submitted immediately following the on-site reivew to Medicaid agency supervisory staff so that participant health and safety can be confirmed. A formal written review must be submitted within two working days.

If the SLF is determined to be out of compliance with regulations, the Medicaid agency may issue findings of non-compliance. The SLF is presented with a form outlining the areas of non-compliance. A plan of correction must be submitted to the Medicaid agency within fourteen days of receiving the form. The plan must be implemented within thirty days. Medicaid agency staff perform an on-site follow-up review to determine compliance and remediation. Persistent non-compliance in making corrections results in sanctions including, but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement.

Additionally, if participants' current health or safety were threatened as the result of the SLF's response to the critical incident, the Medicaid agency may issue an Immediate Jeopardy. Immediate Jeopardy results in Medicaid agency staff staying on-site at the SLF until the areas of non-compliance involving immediate health and safety have been remediated. Immediate Jeopary also requires the SLF to submit and implement a plan of correction within ten days. Medicaid agency staff perform an on-site follow-up review to determine that remediation has occurred. If continued problems exist, the Medicaid agency may suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, Medicaid agency staff assist waiver participants in identifying possible relocation options, including transferring to another SLF.

Critical incident reports are also tracked by the Medicaid agency. Information captured in the tracking report incluces: facility name, Medicaid agency region, type of incident, participant name(s), facility response, timeliness of submission and outcome to monitor for patterns and trends.

Participants and and their families are able to obtain information related to the investigation by contacting the Medicaid agency in writing or by phone. A copy of the investigation report is available through a Freedom of

Information Act request.

The above applies to participants in the dementia program and those enrolled in an MCO as well.

For participants enrolled in an MCO, the Plans will have similar processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and identified issues routed to the appropriate department within the Plan and when indicated to the investigating authority described above. The procedures will include processes for ensuring participant safety while the State authority conducts its investigation.

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 Medicaid agency is responsible for overseeing the operation of the incident management system. All written incident reports submitted by Supportive Living Facilities (SLF) are entered into a statewide incident review report. This report tracks reports by facility name, Medicaid agency region, type of incident, participant name(s), facility response,timeliness of submission and outcome to monitor for patterns and trends.

The incident review report is examined by the Medicaid agency on a quarterly basis. This allows the agency to identify and respond to any patterns, trends or repeated occurences within a specific facility, with a provider operating multiple facilities, or in a particular region and/or statewide. Problems identifed statewide or in a certain region can be responded to by issuing clarifications via a provider notice to all facilities and/or by offering provider training. Patterns and trends seen within a specific facility or group of facilities may result in the Medicaid agency issuing findings for non-compliance and/or supplying technical assistance and clarifications to the facility(ies). In the case of findings, an SLF would be required to develop and implement a plan of correction within thirty days of receipt of the findings. Medicaid agency staff perform an on-site follow-up review to verify remediation has occurred and determine compliance with adminstrative rules.

Reviews of required critical incident reporting is also done on an annual and ongoing basis during on-site annual certification reviews and complaint investigations. While on-site, Medicaid agency staff review participant and facility records to confirm that the SLF has submitted critical incident reports as required.

These procedures also apply to the dementia program and participants enrolled in an MCO.

In addition, for participants enrolled in an MCO, the Plans will maintain an internal reporting system for tracking the reporting and response to critical incidents, and analysis of the event to determine whether individual or systemic changes are needed. Critical incident reporting will be included in the reporting requirements to the Medicaid agency. The Medicaid agency monitors both compliance of performance measures and timeliness of remediation for those waiver participants enrolled in an MCO. Participants 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 Medicaid agency is responsible for identifying any unauthorized use of restraints or seclusion. Oversight activities occur during on-site visits, including annual certification reviews, complaint investigations, scheduled technical assistance visits and unannounced monitoring visits.

During annual on-site certification reviews (bi-annual reviews occur for the dementia program), Medicaid agency staff review participant records and also interview and inspect the apartments of a representative random sample of participants. Participants are asked if they have been informed and are aware of their rights. This includes the right to be free of restraints. Participants are also questioned about the satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the apartment inspection process, Medicaid agency staff have the opportunity to see any physical restraints.

The unauthorized use of restraints could also be brought to the Medicaid agency's attention via the toll-free complaint hotline, e-mail or written correspondence. Anyone including but not limited to, participants, their families and facility staff, may register a complaint. Medicaid agency staff must perform on-site investigations in response to complaints received.

Medicaid agency staff may also conduct unscheduled facility visits for the combined purposes of monitoring and providing technical assistance to supportive living facilities. These visits provide another opportunity for Medicaid agency staff to detect the unauthorized use of restraints. Furthermore, the State Long Term Care Ombudsman Program would inform the Medicaid agency if staff become aware of or suspected the unauthorized use of restraints in an SLF.

If a supportive living facility (SLF) is found to be out of compliance by using restraints with participants, the Medicaid agency would issue a finding of non-compliance. The SLF is presented with a form outlining the areas of non-compliance. A plan of correction must be submitted to the Medicaid agency within fourteen days of receipt of the form. The plan must be imlemented within thirty days. Medicaid agency staff perform an on-site follow-up visit to verify the use of restraints was no longer being practiced.

Additionally, if a participant's current health or safety were threatened by the use of the restraints, the Medicaid agency may issue an Immediate Jeopardy. Immediate Jeopardy results in Medicaid agency staff staying on-site at the SLF until the areas of non-compliance have been remediated, if the participant is at-risk at the time of the on-site review. Immediate jeopary also requires the SLF to submit and and implement a plan of correction within ten days of receipt of the findings. Medicaid agency staff perform an on-site follow-up review to determine that remediation has occurred. If continued problems exist, the Medicaid agency will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement was terminated, Medicaid agency staff would assist waiver participants in identifying possible relocation options, including transferring to another SLF.

These procedures also apply to the dementia program and those enrolled in an MCO. Additionally, the MCO detects unauthorized use of restraints and/or seclusion through face-to-face visits, routine contacts with participants, and possibly through complaint or incident reporting. If the Plans identify or learn of the use of restraints and/or seclusion, it will be reported as a reportable incident and reported to the investigation authorities as indicated. In this instance the Plan will be reponsible for overseeing the waiver participant 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 Medicaid agency is responsible for identifying restrictive interventions. Oversight activities occur during on-site visits, including annual certification reviews, complaint investigations, scheduled technical assistance visits and unannounced monitoring visits.

During on-site annual certification reviews, Medicaid agency staff review participant records and also interview participants. Participants are asked if they have been informed and are aware of their rights. They are also asked about their satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the record review, Medicaid agency staff have the opportunity to identify the use of restrictive interventions.

The use of restrictive interventions can also be brought to the Medicaid agency's attention at any time via the toll-free complaint hotline, e-mail or written correspondence. Anyone, including participants, their families and facility staff, may register a complaint. Furthermore, the State Long Term Care Ombudsman Program would inform the Medicaid agency if staff become aware of or suspected the use of restrictive interventions in an SLF. Medicaid agency staff must perform on-site investigations in response to complaints received.

Medicaid agency staff may also conduct unscheduled facility visits for the combined purposes of monitoring and providing technical assistance to supportive living facilities. These visits provide another opportunity for Medicaid agency staff to detect the unauthorized use of restrictive interventions.

If a supportive living facility (SLF) is found to be out of compliance for adopting the use of restrictive interventions with participants, the Medicaid agency would issue a finding of non-compliance. The SLF would then be required to submit a plan of correction to the Medicaid agency within fourteen days of receipt of the findings. The plan must be implemented within thirty days. Medicaid agency staff perform an on-site follow-up review to ensure the use of restrictive intervention was no longer being practiced.

Additionally, if a participant's current health or safety were threatened by the use of the restrictive interventions, the Medicaid agency may issue an Immedicate Jeopardy. Immediate Jeopardy results in Medicaid agency staff staying on-site at the SLF until the areas of non-compliance have been remediated, if the participant is at-risk at the time of the on-site review. Immediate jeopary also requires the SLF to submit and and implement a plan of correction within ten days of receipt of the findings. Medicaid agency staff perform an on-site follow-up review to determine that remediation has occurred. If continued problems exist, the Medicaid agency will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement was terminated, Medicaid agency staff would assist waiver participants with identifying possible relocation options, including transferring to another SLF.

Dementia program residents' safety needs are met with a service intervention of alarmed, delayed exit doors. When the door's release bar is pushed, an alarm sounds and the door will open if the bar is pushed for several continous seconds. Dementia participants have the freedom to move within the dementia facility, including access to secured outdoor common space.

Participation in the dementia program is voluntary. The participant, his/her physician, family and dementia program staff collaborate to determine if the dementia program is a beneficial setting. The need for extra supervision is based on a participant's individual characteristics and needs for care and support. All dementia participants must have an elopement risk assessment completed prior to admission and quarterly thereafer by a registered nurse to determine if alarmed, delayed exit doors are a necessary safety service intervention. If a participant is assessed to no longer require this intervention, facility staff discuss a different community placement with the participant and his/her designated representative. Medicaid agency staff review the elopement risk assessments during bi-annual reviews.

Dementia program participants are allowed to leave at any time with staff, family or other designated representatives. Dementia participants may also have visitors at any time. Visits by family and friends are encouraged and do not have to be prearranged with the facility. Staff are available 24 hours per day to allow visitors access to the building.

Medicaid agency staff complete bi-annual on-site certification reviews for the dementia program. 100% of waiver participants receive records reviews, are observed by Medicaid agency staff and also interviewed. Medicaid agency staff verify that participants have been appropriately assessed and that the assessment is timely, complete and accurate. Participant access to common areas is also verified. If program non-compliance were identified, the process outlined above for conventional supportive living facilities would also be followed for dementia facilites.

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 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.

Supportive living facilities (SLF) are responsible for conducting monitoring of medication regimens for participants who choose to receive medication management services from the SLF.

Information regarding participant prescriptions is obtained at the time of the initial assessment, which is conducted within 24 hours of admission. The initial assessment should include a participant's medications, dosage, frequency and any assistance they require or request. This information is captured again during the comprehensive resident assessment completed within 14 days of admission. The Resident Assessment Instrument (RAI) is the comprehensive assessment tool designated by the Medicaid agency for use in SLFs. Each participant's RAI must contain a listing of diagnoses, medications, including over the counter medications, dosage and frequency. After the comprehensive assessment, medication regimens are reviewed and updated as needed after physcian visits, hospitalizations or a change in a participant's condition. At a minimum, a participant's medication regimen must be assessd on a quarterly basis during required reviews. A licensed nurse is responsible for these assessments.

As part of the comprehensive resident assessment, a participant's ability to safely manage his/her own medication is examined. If a participant requires assistance, either in the form of medication set up, reminders, cuing for self-administration or medication administration, this is included in the resident service plan (RSP).

Additionally, a Medicaid agency form must be completed for medication errors indentifed by the SLF. SLF staff is reponsible for completing this form, which includes a summary of the error, information regarding the notification of the particpant's physician and a plan of correction. The same process for medication errors is required for dementia program participants and those enrolled in an MCO.

For participants enrolled in an MCO, SLFs must notify the Plans of medication errors as required.

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.

The Medicaid agency is reponsible for monitoring medication management services provided to waiver participants by supportive living facility (SLF) staff. Records of waiver participants are reviewed extensively during on-site annual certification reviews. This includes examining comprehensive resident assessements, resident service plans (RSP), physician orders and medication managment services records. Medicaid agency staff may also observe the delivery of medication management services by SLF staff.

During the record review, Medicaid agency staff make sure the participant's assessment corresponds with the RSP and the correct medication management service is identified. Medicaid agency staff also verify that RSPs are implemented and that participants receive all of the services contained in the plan. Medication management service records are reviewed to verify required information is included, such as staff initials/signatures indicating the service was provided. Additionally, Medication Error Reports are reviewed by Medicaid agency staff to verify reports were completed as required, physicians were notified and a plan of correction to prevent errors in the future was implemented.

If Medicaid agency staff discover medication errors and/or physician's orders are not followed in regards to medication management services, finding(s) of non-compliance could be issued. The supportive living facility (SLF) is presented with a form outlining areas of non-compliance. A plan of correction must be submitted to the Medicaid agency within fourteen days. The plan must be implemented within thirty days. Medicaid agency staff perform an on-site follow-up review to determine compliance and remediation. Persistent non-compliance in making corrections results in sanctions including, but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement.

Additionally, if a participant's current health or safety were threatened as the result of medication management services not being provided appropriately, the Medicaid agency may issue an Immedicate Jeopardy. Immediate Jeopardy results in Medicaid agency staff staying on-site at the SLF until the areas of non-compliance have been remediated, if the participant is at-risk at the time of the on-site review. Immediate jeopary also requires the SLF to submit and and implement a plan of correction within ten days. Medicaid agency staff perform an on-site follow-up review to determine that remediation has occurred. If continued problems exist, the Medicaid agency will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement was terminated, Department staff would assist waiver

participants with identifying possible relocation options, including transferring to another SLF.

The same procedures apply for the dementia program and participants enrolled in an MCO.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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).

Supportive living facilities (SLF) are required to provide medication management services. Depending upon participant needs and preferences, SLFs offer a spectrum of medication management services. These include medication set-up, verbal reminders, assistance with self-administration and medication administration (89 IL Admin. Code, Chap. I, Section 146.230(b)(2-3) "When a resident is unable to administer his or her own medications, a licensed nurse shall administer the medications', "Nursing services shall include medication set-up (such as preparing weekly pill caddies with that week's medication" and (d) "Medication Administration, Oversight and Assistance in Self-Administration").

As provided in the Nurse Practice Act [225 ILCS 65], only licensed nursing staff (registered or licensed practical nurse) may set-up medications or administer medications. Certified nursing assistants (CNA) are allowed to perform verbal medication reminders, hand participants their set-up medication from where it is stored and open medication containers.

SLF staff must document medication management services icluding the date, time, and staff signature/initials.

The same requirements apply to the dementia program and participants enrolled in an MCO.

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:

All Medication errors that occur for participants receiving medication mangement services from the supportive living facilities (SLF) are required to be recorded on a Medicaid Error Report form. Medication errors that result in adverse reactions requiring hospitalization must be reported on the required form to the Medicaid agency within 24 hours. All other errors are recorded on the Medication Error Report form and made available to the Medicaid agency at its request. The form includes the name of the participant involved, the medication(s) and the type of error (i.e. time, dosage, etc) and any adverse reaction observed. Additionally, the SLF must document that the physician and emergency contact were notified and include information regarding any instructions provided by the physician. Finally, the SLF must provide a plan of correction to prevent additional errors. These requirements also apply to the dementia program and participants enrolled in an MCO.

For participants enrolled in an MCO, the Plans will have similar processes and procedures in place to receive medication error reports. These will be routed to the appropriate department within the Plan and when required to the Medicaid agency. The procedures will include processes for ensuring participant safety. The Plans will also track medication errors requiring reporting to the Medicaid agency and report on a quarterly basis.

(b) Specify the types of medication errors that providers are required to *record:*

Medication errors must be reported for particpants who receive medication management services from the supportive living facility (SLF). These services include medication set-up, verbal reminders and administration. The Medicaid agency defines a medication error as the wrong medication, wrong dose, wrong time (in excess of one hour in most instances), wrong route or a missed medication. These reports must be made available at the Medicaid agency's request.

(c) Specify the types of medication errors that providers must *report* to the State:

Medication errors that result in adverse reactions requiring hospitalization must be reported in writing to the Medicaid agency within 24 hours on the Medicaid Error Report form. The form includes the name of the participant involved, the medication(s) and the type of error (i.e. time, dosage, etc) and any adverse reaction observed. Additionally, the SLF must document that the physician and emergency contact were notified and include information regarding any instructions provided by the physician. Finally, the SLF must provide a plan of correction to prevent additional errors.

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.

Medicaid agency staff monitor medication management services received by waiver participants annually during on-site certification reviews and also continuously and ongoing in response to complaints. During on-site reviews, the records of participants are reviewed, including documentation of medication management services and physician's orders, as well as Medication Error Reports. Medicaid ageny staff verify participants are receiving the medication services they need based on their comprehensive assessment, that physician orders are followed and that medication management services are documented as required. Medication Error Reports are reivewed for completeness and accuracy. Medicaid agency staff also verify that medication administration is being performed only by licensed nurses. Participants and staff may also be interviewed. Medicaid agency staff can observe the delivery of medication management services if necesary.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

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

Performance Measures

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

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

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
#/% of waiver partic.s' instances of alleged abuse, neglect, exploitation other crimes approp. reported to the Dept., MCO and local law enforcement. N: # of waiver partic.s' instances of alleged a/n/e and other crimes approp. reported to the Dept., MCO and local law enforcement. D: Total # of waiver partic. with instances of alleged abuse, neglect, exploitation and other crimes.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports/EQRO 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: MCO/EQRP	**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: MCO	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
Number/percent of incident reports requiring additional review by the Department within the required timeframes as described in the approved waiver. Numerator: Number of incident reports requiring additional review that were investigated by the Department within the required timeframes. Denominator: Total number of incident reports that required additional review.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

		Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number/percent of interviewed waiver participants who report their rights, choices and preferences are respected. Numerator: Number of interviewed waiver participants who report their rights, choices and preferences are respected. Denominator: Total number of waiver participants interviewed.

Data Source (Select one):
Participant/family observation/opinion
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 = +/- 5
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:
Number/percent of medication errors documented and reported to the Department. Numerator: Number of medication error reports documented and reported to the Department. Denominator: Total number of incidents of medication errors requiring documenting and reporting to the Department.

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

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

collection/generation *(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 Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports/EQRO 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: MCO/EQRP	**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: MCO	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
Number/percent of waiver participants who receive well-being checks in accordance with the approved waiver. Numerator: Number of waiver participants receiving well-being checks in accordance with the approved waiver. Denominator: total number of waiver participants 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 =

		+/- 5
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:
Number/percent of waiver participants who have working emergency call systems in their apartments. Numerator: Number of waiver participants with working emergency call systems in their apartment. Denominator: Total number of waiver participants reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
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 = +/- 5
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:
Number/percent of waiver participants who are free from seclusion or restraints. Numerator: Number of waiver participants who are free from seclusion or restraints. Denominator: Total number of waiver participants reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
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 = +/- 5
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

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 = +/- 5
Other Specify:	**Annually**	**Stratified** Describe Group:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports/EQRO 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: MCO/EQRO	**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: MCO	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
Number/percent of waiver particpants whose funds are mananged by the SLF according to Department regulations. Numerator: Number of waiver participants whose funds are managed by the SLF according to Department regulations. Denominator: Total number of waiver participants reviewed who are receiving managment of funds by the SLF.

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

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

collection/generation *(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 = +/- 5
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:
Number/Percent of dementia waiver participants who had an elopement risk assessment completed according to program requirements. Numerator: Number/Percent of dementia program waiver participants who had an elopement

risk assessment completed according to program requirements. Denominator: Total number of dementia waiver participants 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 =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify: Bi-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

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

Performance Measure:
#/% of dementia prog. partic.s' instances of alleged abuse, neglect, exploitation and other crimes approp. reported to the Dept. and local law enforc. N:# of dementia prog. partic.s' instances of alleged abuse, neglect, exploitation and other crimes approp. reported to the Dept. and local law enforc. D:Total # of dementia prog. partic. with alleged abuse, neglect, exploitation and other crimes.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number/percent of interviewed dementia program waiver participants who report their rights, choices and preferences are respected. Numerator: Number of interviewed dementia program waiver participants who report their rights, choices and preferences are respected. Denominator: Total number of dementia program waiver participants interviewed.

Data Source (Select one):
Participant/family observation/opinion
If 'Other' is selected, specify:

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

Bi-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:

Performance Measure:
Number/percent of dementia program waiver participants who receive well-being checks in accordance with the approved waiver. Numerator: Number of dementia program waiver participants receiving well-being checks in accordance with the approved waiver. Denominator: Total number of dementia program waiver participants 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 =
Other Specify:	**Annually**	**Stratified** Describe Group:

	Continuously and Ongoing	**Other** Specify:
	Other Specify: Bi-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:

Performance Measure:
Number/percent of medication errors for dementia program waiver participants reported to the Department. Numerator: Number of medication error reports for dementia program waiver participants documented and reported to the Department. Denominator: Total number of incidents of medication errors for dementia program waiver participants requiring documenting and reporting to the Department.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medication Error 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: Bi-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:

Performance Measure:
Number/percent of dementia program waiver participants who have working emergency call systems in their apartments. Numerator: Number of dementia program waiver participants with working emergency call systems in their apartment. Denominator: Total number of dementia program waiver participants reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

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

Performance Measure:
Number/percent of dementia program waiver participants who are free from seclusion or restraints. Number/percent of dementia program waiver participants who are free from seclusion or restraints. Denominator: Total number of dementia program waiver participants reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

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

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

	Continuously and Ongoing	**Other** Specify:
	Other Specify: Bi-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:

Performance Measure:
#/% of dementia partic. referred to another setting when the elopement risk assess. no longer showed a need for an alarmed, delayed exit door intervention. Numerator:# of dementia partic. referred to another setting when the elopement risk assess. no longer showed a need for an alarmed, delayed exit door intervention. Denominator:Total # of dementia partic. requiring referral to another setting.

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

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

		Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify: Bi-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:

Performance Measure:
Number/percent of dementia program waiver participants whose funds are managed by the SLF according to Department regulations. Numerator: Number of dementia program waiver participants whose funds are managed by the SLF according to Department regulations. Denominator: Total number of dementia program waiver participants reviewed who are receiving management of funds by the SLF.

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

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

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

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.

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.

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.

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 samples for the record reivews, apartment observations and interviews for following performance measures will be completed by Medicaid agency staff. These will include separate samples for MCO and non-MCO enrollees. The samples for MCO enrollees with be proportionate among the MCOs. These samples, like the ones for non-MCO residents, will be less than 100% review, but will have a 95% confidence level and a 5% margin of error. This applies to dementia program residents as well. All of these PMs apply to participants enrolled in an MCO.

--resident rights/choices/preferences
--functioning emergency call lights
--well-being checks
--freedom from restraints/seclusion
--medication errors
--management of resdient funds
--elopement risk assessment for those in the dementia program

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The state Medicaid agency (MA) is responsible for insuring individual problems are resolved.

Incident reporting:
If a supportive living facility (SLF) did not report alleged abuse, neglect, exploitation or another crime against a waiver participant to the MA, MCO and local law enforcement, it would be required to be submitted at the time this was discovered by the MA. MA staff would review the required Preliminary Incident Report for completeness and accuracy to confirm remediation. In a case of alleged participant abuse, neglect or exploitation, the Medicaid agency would confirm local law enforcement had been notified. If a participant's safety was a concern at the time the allegation of abuse, neglect or exploitation was discovered, the MA would review what steps the SLF had taken to keep the resident safe, such as placing an accused employee on administrative leave pending an investigation, and determine if further steps needed to be taken. MA staff could also assist the participant with identifying temporary or permanent relocation options as well.

The MA also tracks incidents by type, facility, and participant to monitor for patterns.

MA Review of Incident Reports:
If MA staff were found to be late with conducting on-site reviews related to incident reports or submitting summaries as required, the investigation/report would have to be completed and immediately. Staff would also receive technical assistance/training regarding agency procedures involving follow-up for incident reports. Continued non-compliance could result in administrative personnel action.

Participant Rights/Choices:
If a particpant alleged his/her rights or choices were not being respected, MA staff could investigate further. This could include reviewing the partipant's record, interviewing staff and other participants and reviewing facility policies. If the MA discovered resident rights were not respected, findings of non-compliance could be issued(see below).

Medication Error Reports.
If it was discovered a Medication Error Report requiring submission to the MA had not been sent, the SLF would need to complete a report (if not previously done) and send it. MA staff would review the report form for completeness and accuracy to verify remediation.

Well-being Checks:
If it was found a waiver participant did not have required well-being checks completed timely, the MA could issue findings of non-compliance (see below). If checks had not been completed at all, MA staff would stay on-site at the facility until this occurred to verify remediation.

Emergency call systems:
If a participant was found to not have a working emergency call system, the SLF would have to repair the system immediately or supply an alternative way for the particpant to signal for help approved by the MA, until the system could be repaired. MA staff would verify the system was repaired to document remediation.

Freedom from Restraints & Seclusion:
If a particpant was found to be in/have been in restraints or seclusion, the SLF would need to immediately discontinue the practice. MA staff would verify the partipant was not in restraints or seclusion in order to document remediation. In addition to the issuance of findings of non-compliance summarized below, the MA may also issue an Immediate Jeopardy, as outlined earlier in this section, if the participant was identified to be in immediate danger.

Mangement of Resident Funds:
If a particpant's funds were found not to be managed by the SLF in accordance with regulations, Medicaid agency staff would instruct the SLF to correct the issue. For instance, if particpants had not been provided with the required periodic accounting of their funds, the SLF would have to issue these reports. MA staff would confirm participants received this information so that remediation could be verified. If it was suspected the SLF was intentionally mismanaging particpants' funds, the Medicaid agency's Office of Inspector General (OIG)would be notified to further investigate the matter and pursue legally as necessary. Depending on the situation, the Illinois State Police could become involved at the request of the OIG.

Elopement Risk Assessment (dementia program ONLY):
If an elopement risk assessment had not been completed, one would be required to be completed. Medicaid agency staff would verify the completion of the assessment. If facility staff did not refer a dementia program waiver participant to another community setting when their elopement risk assessment no longer indicated a need for an alarmed, delayed exit door service intervention, this referral would be required to be made

immediately. Medicaid agency staff would perform follow-up to verify the referral information had been provided to the dementia program participant or his/her designated representative.

In all cases of individual non-compliance outlined above, the Medicaid agency could issue findings of non-compliance for individual problems when discovered, including for the dementia program and for participants enrolled with a MCO. The SLF is presented with a form outlining the areas of non-compliance. A plan of correction must be submitted to the Medicaid agency within fourteen days of receipt of the form. The plan must be implemented within 30 days. Medicaid agency staff performs an on-site follow-up reivew to determine compliance and remediation. If non-compliance is still identified, the SLF receives a form outlining the current non-compliance areas and is given another 30 days to correct. Continued non-compliance during a 2nd on-site follow up review by Medicaid agency staff results in sanctions, including but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, Medicaid agency staff would assist waiver participants with relocation options, including transferring to another SLF.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 2)

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;
- 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 2)

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 is responsible for the overall development and implementation of the Quality Improvement Strategy (QIS) for the Supportive Living Program waiver. Medicaid agency staff performs on-site reviews to determine if requirements of the program are being met, and insure remediation occurs when necessary. Annually, formal reports containing aggregated discovery and remediation data are compiled and reviewed by the Medicaid agency. This can occur more frequently if it is suspected there is a significant issue of non-compliance with regulations. Additionally, reports specific to performance measures undergoing system changes are distributed to members so that outcomes can be assessed and revisions made to the system changes if necessary. The timing of these reports is determined by the Quality Workgroup and depend on severity of the non-compliance involved, its impact on health and safety and how widespread. Additionally, the MCO's are responsible for some data collection related to performance measures as indicated in the waiver and are required to submit reports to the SMA on a quarterly and annual basis.

A Quality Workgroup assembled by the Medicaid agency assists with the QIS development, processes, implementation and monitoring. The workgroup is a collaboration of Medicaid agency staff, including those involved with other HCBS waivers, supportive living facility providers, trade association staff and long term

care ombudsman. Members review QIS data and reports compiled by the Medicaid agency in order to respond to patterns and trends that identify a need for system improvements, as well as monitoring ongoing quality improvement. The Quality Workgroup formally meets twice a year to discuss overall QIS issues, report on developments within smaller groups, called Assurance Teams, devise responses to needed quality improvements and monitor outcomes for system changes. Assurance Teams are assigned to specific assurances/subassurances required by the approved waiver. They are responsible for identifying and responding to patterns or trends requiring system improvements and subsequently developing a proposed QIS strategy to respond. Assurance Teams meet more frequently, as their assignments require. Team members draft proposed system improvement recommendations, including performance measures, possible remediation, data sources and how improvement will be measured. These proposals are then presented to the Quality Workgroup to establish priority and final approval. Meeting minutes are taken and distributed to Workgroup members. Medicaid agency staff are responsible for follow-up at subsequent meetings to make sure action items identified and assigned at a previous meeting, per the meeting minutes, are addressed.

The QIS process begins with Medicaid agency staff compiling discovery and remediation information from annual certification reviews, complaint investigations, critical incident reports, medication error reports and other sources identified in the approved waiver. This data is assembled into individual reports specific to the performance measures identified in the approved waiver. Information in the reports includes the numerator and denominator of the performance measures, data sources and also any identified patterns or trends for a particular geographic area of the state or provider group. The data collection from the MCOs will contain the same information. Reports are shared with all Quality Workgroup members.

Performance measures with less than 100% compliance are identified as areas in need of system improvement. Identified system improvement areas are then prioritized by Workgroup members based on severity, impact on waiver participant health and safety, frequency and geographic distribution of occurrences. Once prioritization is established, performance measures requiring system improvement are delegated to the appropriate Assurance Teams. Members then begin developing interventions for possible system design changes. Data sources and options for measuring each system design change are also identified so that continuous quality improvement can be tracked.

Examples of interventions for system design changes could include:
- Program administrative rule changes
- Program policy and procedure changes
- Written clarification for waiver provider and/or Medicaid agency staff
- Resource tools for waiver provider and/or Medicaid agency staff
- Formal staff training
- Standardized forms

The Quality Workgroup will also focus on the Supportive Living Program's compliance with providing a "homelike setting" and offering participants opportunities for involvement with the larger community. Information from annual/bi-annual on-site certification reviews and complaint investigations will be collected and analyzed to insure supportive living facilities continue to offer a "homelike" setting. This will include observation of facility common space and individual particpant apartments. Additionally, data will be collected related to participant access to the larger community, including a review of scheduled activities, the participant assessment specific to personal interests along with participant interviews. This data is tracked and aggregated by the State Medicaid agency and shared with the Quality workgroup for analysis along with other quality management data. Analysis of the data includes review of remediation of non-compliance and monitoring for patterns and trends, including statewide trends or those within a certain region or provider. Performance measures requiring system improvement are delegated to the appropriate Assurance Teams. Members then begin developing interventions for possible system design changes. Data sources and options for measuring each system design change are also identified so that continuous quality improvement can be tracked.

For quality management of managed care, the Medicaid agency will meet with the MCOs on a quarterly basis to review data collected. All reports will be provided to the Medicaid agency for review prior to the quarterly meetings. Annual reports will be produced identifying trends based on the representative sample and/or 100% review of the data. Data will be reported by individual performance measures. Data to be reported will include level of compliance and timeliness of remediation based on immediate, 30, 60, 90 day increments and any outstanding remediation.

During quarterly meetings, the Medicaid agency and MCO will identify trends based on scope, severity, changes and patterns of compliance by reviewing both the levels of compliance with the performance measures and remediation activities conducted by the MCOs. Identified trends will be discussed and analyzed regarding cause, contributing factors and opportunities for system improvements. Systems improvement will be prioritized based on the overall impact to the participants and the program. System

improvements may be prioritized based on factors such as: the impact on the health and welfare of waiver participants, legislative considerations and fiscal considerations. The MCOS will maintain a separate quality management system and improvement logs. Recommendations for system improvements will be added to the log(s) for tracking purposes. The MCOs will document the systems improvement implementation activities on its respective log. The Medicaid agency will assure that the recommendations are followed through to completion. Decisions and time lines for system improvement will be made based on consensus of priority and specific steps needed to accomplish change. These decisions will be documented on the systems improvement log and will be communicated through the sharing of the quarterly meeting summary and the systems improvement log.

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: More frequently as required for monitoring of system changes.

b. System Design Changes

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

The performance of system design changes are monitored by the Medicaid agency through the collection and analysis of new performance measure data, as well as the comparison of previous data and patterns and trends. Once the need for a system change is identified by the Quality Workgroup, the appropriate Assurance Team develops a proposed system change(s), recommended data source(s), samples size(s) and a measure(s) for tracking the outcome(s). The proposed processes above are outlined by the Assurance Teams and presented to the Quality Workgroup. The Quality Workgroup discusses and determines the final change(s) to be implemented, which data source(s) will be used and how improvement will be measured.

Once the data source is identified, it is assigned to a database tracking system to capture information from on -site annual reviews, complaint investigations or other designated sources. Medicaid agency staff is responsible for the collection of this data and entering it into the database. Any required changes to Medicaid agency policy and procedures, review tools or standardized forms are made and distributed to the appropriate parties. Medicaid agency staff will develop reports specific to the system changes and related performance measures so that outcomes may be analyzed by the Assurance Team and Quality Workgroup as a whole. Outcomes for system changes will be tracked for a minimum of one year. The Assurance Team will provide the Quality Workgroup with a summary of the performance of the system changes based on the outcomes. The Team will make recommendations as necessary for any revisions to the system changes and explain why they are necessary. The Quality Workgroup will discuss and any approved revisions to the system changes will be implemented, as outlined in the process above. This process will be repeated until such time as the system change has proven to be an effective QIS strategy. A system change will continue to be monitored for at least one additional year after it is deemed an effective QIS strategy to insure continued quality improvement is demonstrated. The Quality Workgroup may also choose to designate the system change as a permanent part of the continuous quality improvement process.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Workgroup meets formally biannually to review and evaluate the QIS, including any in-process system changes. Reports containing data individualized for specific performance measures are developed by the Medicaid agency and distributed to Workgroup members. Patterns and trends, areas requiring system changes and any areas currently undergoing improvement are discussed. Additionally, at the request of an Assurance Team, the Medicaid agency can compile data reports for performance measures at any time, if the

members are interested in reviewing system change outcomes more frequently.

The overall QIS is evaluated by Quality Workgroup Members at least annually. This includes evaluating current monitoring practices to insure the information being gathered is the best data source for the performance measure, if the sample size is appropriate and also if Meidcaid agency staff are interpreting the review process appropriately. Additionally, the Workgroup will review the priority ranking of system changes to verify that all areas impacting participant health and safety are being addressed.

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).

Supportive Living Program providers are paid directly by the Medicaid agency through a process that is similar to that of nursing facilities. A flat rate is paid for each day a Medicaid participant resides in a supportive living facility (SLF). SLF payments are generated based on participant data entered into the Medicaid agency's long term care data base by the Department of Human Services (DHS) caseworkers. Information regarding participant admission, conversion to Medicaid, discharge and death are communicated to the DHS caseworker, either electronically or via Medicaid agency forms. The DHS caseworker enters this information into the long term care data base. SLF payments are then generated from MMIS based on the information in the data base.

The SLF receives a monthly prepayment report and is required to identify and inform the Medicaid agency of any inaccuracies in this report from which the claim is generated. Additionally, a SLF representative must sign a remittance advice that accompanies each payment voucher to verify that the facility accepts the payment amount is correct. The prepayment reports, remittance advice and signature certification documents must be kept on file by the SLF for three years. The Medicaid agency's Office of Inspector General audits these documents.

All SLP providers are paid directly by the Medicaid agency. The automatic payment system that is in place for SLFs through MMIS, does not necessitate the need for a process of financial oversight to assure claims are coded and paid in accordance with the reimbursement methodology. A financial monitoring process for verifying maintenance of appropriate financial records is also not required. SLFs do not submit or retain any financial records because no bills or claims are required for payment. There are not any waiver participant claims to review and verify they are coded and paid in accordance with the waiver reimbursement methodology.

SLFs are required to perform independent audits conducted annually by certified public accountants. Copies of audits and reviews must be provided to the Medicaid agency.

The Medicaid agency's Office of Inspector General perform audits at SLFs as well. The scope of the review for SLFs includes current participants and also those discharged within the period of the review. Areas reviewed include: room and board ledgers, required Medicaid agency forms related to payment generation, disbursement of participant personal allowance, temporary bed reserves for vacation stays and participant cost of care received by the SLF. A random sample of SLFs are audited annually.

Klynveld, Peat, Marwick, Goerdeler (KPMG), under the auspices of the State Auditor General's office, is responsible for the provisions of the Single Audit Act.

All services for which charges are made to the Medicaid agency are subject to audit. During a review audit, the provider must furnish to the Medicaid agency or to its authorized representative, pertinent information regarding claims for payment. Should an audit reveal that incorrect payments were made, or that the provider's records do not support the payments that were made, or should the provider fail to furnish records to support payments that were made, the provider must make restitution.

The Medicaid agency's procedure for auditing providers involves the use of sampling and extrapolation. Under such a procedure, the Medicaid agency selects a statistically valid sample of cases for which the provider received payment for the audit period in question and audits the provider's records for those cases. All incorrect payments determined by an audit of the cases in the sample are then totaled and extrapolated to the entire universe of cases for which the provider has been paid during the audit period. The provider is required to pay the Medicaid agency the entire extrapolated amount of incorrect payments calculated under this procedure after notice and opportunity for hearing.

For participants enrolled in a MCO, the Medicaid agency's internal and external auditing procedures will ensure that payments are made to a managed care entity only for eligible persons who have been properly enrolled in the waiver.

The Plans are responsible for reviewing payments made directly to providers for waiver services as part of the Integrated Care Program (ICP). The plans must have an internal process to validate payments to waiver providers. This includes the claims processing system verifying an individual's waiver eligibility prior to paying claims. This will be reviewed in the Readiness Review.

Post-payment plans of care and financial reviews are also conducted. Additionally, the Plans will implement call-in checks for some waiver services to verify a provider was on-site as required during the specified time(s) and post service verification forms for participants to validate they received services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(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:
Number/percent of payments made by the Medicaid Agency for individuals enrolled in the Medicaid waiver. Numerator: Number of payments made by the Medicaid Agency to waiver providers and MCOs for individuals enrolled in the Medicaid waiver. Denominator: Total number of waiver provider and MCO payment records reviewed.

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

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 = +/- 5
Other Specify:	**Annually**	**Stratified** Describe Group: Managed care enrollees will be part of a stratified random sample.
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: 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: MCO	**Annually**
	Continuously and Ongoing
	Other Specify: Semi-annually

Performance Measure:
Number/percent of payments made for waiver services using correct reimbursement rate. Numerator: Number of waiver provider and MCO payments made for waiver services using the correct reimbursement rate. Denominator: Total number of waiver provider and MCO payment records reviewed.

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

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 = =/- 5
Other Specify:	**Annually**	**Stratified** Describe Group: Managed care enrollees will

		be part of a stratafied random sample for each participating MCO.
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: 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: MCO	**Annually**
	Continuously and Ongoing
	Other Specify: Semi-annually

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.

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 contracted entity, the Medicaid agency is responsible for discovery. The Medicaid agency monitors both compliance of performance measures and timeliness of remediation for those waiver participants enrolled in a MCO. Participants in MCOs are included in the representative sampling. This review will include encounter claims submitted by MCOs. A random stratafied sample of MCO enrollees will be reviewed.

Monintoring of the use of the correct reimbursement rate will require review of claims data and encounter data pulled from the medical data warehouse. Claims will be priced by procedure code. The Medicaid agency will determine if the correct rate was used. The MCO rate is the encounter rate that is paid by the Provider. It will be the same as the daily SLF rate specified in the application.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The state Medicaid agency is responsible for insuring individual problems are resolved.

Payment for Non-waiver participant:
If the Medicaid agency discovers that payment has been issued for waiver services for an individual not enrolled in the waiver at all, or for a certain period, a non-allowable service period is identifed. The Medicaid agency would then recover any reimbursement made during the non-allowable service period. Medicaid agency staff would manually change the admission date to the waiver or delete an admission date, as appropriate, in the long term care data base. This would result in MMIS making an automatic adjustment to reduce a future payment to the SLF. Remediation would begin within 30 days of the Medicaid agency confirming a non-allowable service period.

If the individual problem is found to be the result of an error made by a Department of Human Services (DHS) caseworker, the Medicaid agency would communicate this to supervisory staff at DHS. The employee would receive clarification/training regarding correct entry into the long term care database. Continued problems could result in administrative personnel action. Remediation would begin within 30 days of the Medicaid agency confirming the non-allowable service period.

Additionally, the Medicaid agency's Office of Inspector General (OIG) is notified if Medicaid fraud is suspected. Notification of the OIG would occur within 5 working days of the Medicaid agency confirming sustpected Medicaid fraud. If the OIG's investigation resulted in termination of a Medicaid provider agreement, Department staff would assist waiver participants with identifying possible relocation options, including transferring to another SLF.

Incorrect Reimbursement Rate:
If the Medicaid agency discovered an incorrect reimbursement rate was used to generate payment for a waiver participant, the provider reimbursement database would be corrected to reflect the correct reimbursement rate. Correction to the reimbursement rate for waiver services would be generated automatically by MMIS based on the revised rate. This would result in an adjustment, either up or down, to future payment. Remediation would begin within 30 days of the Medicaid agency confirming an incorrect reimbursement rate was paid.

Additionally, the Medicaid agency's Office of Inspector General (OIG) would be notified if Medicaid fraud was suspected.

For those functions delegated to the contracted entity, the Plans are responsible for addressing individual problems as they are discovered. The SMA will monitor both compliance and timely remediation through monitoring and reporting by the Plans.

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 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).

Payment for the Supportive Living Program is a flat rate for each day a Medicaid participant resides in a supportive living facility (SLF). It is not tied to the type of service or the frequency, however, the SLF must provide services that meet a participant's needs.

The Medicaid agency is responsible for determining SLF rates. SLF rates are calculated at 60% of the average weighted nursing facility rate in a specific geographic area. The geographic rate areas used by the Medicaid agency were taken from the Health Service Areas (HSAs) developed by the Illinois Department of Public Health (IDPH). The Medicaid agency changed the name from HSAs because one county (Bond County) was moved out of the HSA assigned by DPH (due to legislative mandate) and moved to another area, thus changing the HSAs groups. These are also the same geographic areas that Medicaid agency uses to set rates for nursing homes. The dementia program rates are 72% of the average weighted dementia care nursing facility rate in a geographic area.

The reimbursement rate methodology for the Supportive Living Program was entered into Administrative Rule, which requires a public comment period. Administrative Rules are available on the Medicaid agency's website and upon request. The Medicaid agency also meets regularly with trade associations, which promotes dialogue regarding reimbursement rates. Additionally, Medicaid agency staff are involved with various state work groups and advisory committees formed around care for the elderly and people with disabilities. Membership includes private individuals, interest groups and advocates. These groups provide input regarding reimbursement rates to the Medicaid agency.

The reimbursement rate methodology is available to participants through the Administrative Rules, which are available on the Medicaid ageny's website or upon request. SLF providers also receive information regarding rates from the Medicaid agency which can be provided to participants. The resident contract, which is reviewed and approved by the Medicaid agency, must contain information regarding payment and rates for the program. Again, the Medicaid reimbursement rate is a flat daily rate.

Room and board rates, including meals, are paid directly by the participant to the supportive living facility and are based on SSI amounts. These payments are separate from the Medicaid agency reimbursement for services.

Capitated rates for waiver services implemented through MCOs were developed by the State's contracted actuary by analyzing historical waiver data information including: enrollment, utilization and paid claims. This information was converted to a Per Participant Per Month (PPPM) basis and stratified by waiver service. The capitated rate for MCOs is a flat monthly rate and is in compliance with 42 CFR 438.6.

Additional information regarding the rate methodology:

Reimbursement for SLF waiver services is a flat daily rate. SLF rates are determined by calculating 60% of the weighted average reimbursement rate for nursing facilities in the same geographic area. The dementia program rates are 72% of the average weighted dementia care nursing facility rate in a geographic area.

The rate methodology for SLF waiver services was initially pegged to 60% of the weighted average reimbursement rate for nursing facilities in the same geographic area, as that was the approximate value of the services (excluding room, board and other Medicaid prohibited costs) provided to residents. As SLF participants are responsible for paying their own room and board, establishment of the state's rate at 60% ensured provision of competitive, geographic-based rates to providers while guaranteeing the cost-neutrality of the waiver.

The rate for SLF waiver dementia services (72% of the average weighted nursing facility rate in a geographic area attributable to residents with dementia) was developed using comparisons of resident care costs in nursing facilities providing dementia care with the rate paid by the Department, which includes a specific add-on to the daily reimbursement rate (excluding room, board and related costs) for each resident receiving these services. Input was sought from the state's trade association representing supportive living facilities regarding actual program cost information and other inclusion of other relevant costs, e.g. liability insurance. The Department also consulted with representatives of the state's Alzheimer's Association to learn about other states' programs, as well as components

of the reimbursement system used by the "private pay" assisted living market in Illinois. In all deliberations and calculations, Department staff was careful to separate the cost of room and board charges paid by participants from any overall rate calculations.

The rate reflects the cost of increased staffing and services necessary to meet the scheduled and unscheduled clinical and supportive service needs of dementia program participants. For instance, a minimum of one certified nurse aide is required for every ten residents in a dementia unit. Licensed nursing services are increased due to participants' needs for medication administration. Additional required services for dementia units that differ from a conventional SLF include well being checks at least once on every shift and scheduled activities a minimum of three times daily. The unscheduled needs of participants in dementia units require more staff interaction as well. For example, increased verbal cuing, redirection and assistance with activities of daily living is provided by staff.

The Department sought to strike a balance between giving providers a reimbursement rate that would allow them to provide safe, quality care to participants in need of dementia services, while still ensuring cost neutrality for the waiver. Department staff analyzed nursing home reimbursement rates for dementia services at various levels to ascertain what level of rate would result in cost effectiveness, while still offering providers a competitive rate. The rate of 72% was the highest percentage that could be justified and still result in cost neutrality.

Reimbursement rates for supportive living facilities are available to the public on the Medicaid agency's website on the Supportive Living Program page.

Currently nursing facility rates from April 2011 are used to calculate the SLF waiver rate while the Medicaid agency is developing a revised rate methodology. The Medicaid agency would like to move from a flat daily rate to a stratified reimbursement system based on the type of services provided. It is anticipated that nursing facility rates will still be included in the rate methodology when developing the stratified system. Providers and advocacy groups will be included in discussions regarding the new reimbursement system. Additionally, new administrative rules would need to adopted, which will require a public comment period. The Medicaid agency will submit another waiver amendment prior to implementation of a new reimbursement system.

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:

Supportive Living Program providers are paid directly by the Medicaid agency through a process that is similar to that of nursing facilities. SLF payments are generated based on participant data entered into the Medicaid Agency's long term care data base by the Department of Human Services (DHS) caseworkers. Information regarding participant admission, conversion to Medicaid, discharge and death are communicated by the SLF to the DHS caseworker through the submission of Medicaid agency forms or via a Data Interchange System. The DHS caseworker enters this information into the long term care data base. SLF payments are then generated from MMIS based on the information in the data base.

The SLF receives a monthly prepayment report and is under contract to identify and inform the Medicaid agency of any inaccuracies in this report from which the claim is generated. Additionally, a SLF representative must sign a remittance advice that accompanies each payment voucher to verify that the facility accepts the payment amount is correct. The prepayment reports, remittance advice and signature certification documents must be kept on file by the SLF for three years. The Medicaid agency's Office of Inspector General audits these documents.

For MCO enrollees, the Medicaid agency pays the MCOs (Plans) a monthly capitated rate for waiver services.

This payment is generated from MMIS based on participants' eligibility in the database system for waiver services. Waiver providers receive payment for services by billing the Plans. The Plans issue payments based on claims received and verification of individual participant waiver eligibility. These claims paid by the Plans are then submitted through the State's MMIS system as encounter data.

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:

Supportive Living Program providers are paid directly by the Medicaid agency through a process that is similar to that of nursing facilities. A flat rate is paid for each day a Medicaid participant resides in a supportive living facility (SLF). Reimbursement is not tied to the type of service provided or the frequency.

Payments are generated based on participant data entered into the Medicaid agency's long term care data base by the Department of Human Services (DHS) caseworkers. Information regarding resident admission, conversion to Medicaid, discharge and death are communicated by the SLF to the DHS caseworker through the submission of Medicaid agency forms. The DHS caseworker enters this information into the long term care data base. SLF payments are then generated from MMIS based on the information in the data base.

The SLF is responsible for notifying DHS within five days when a resident is discharged or passes away. Additionally, MMIS cross references with a database from the Social Security Administration (SSA). If a death is not reported timely by the SLF, information from the SSA system interfaces with MMIS and payments are automatically adjusted accordingly.

If a resident is transferred to a nursing facility and the SLF does not notify DHS, DHS would become aware of the discharge when the nursing facility submits admission documents. Upon entry of the nursing facility admission information into the database, the Department would recoup any payments made to the SLF after the SLF discharge. 89 IL Admin. Code 140.513 requires all facilities to notify the Department within five days of a change in resident status. Facilities with the highest incidences of overpayments are required to participate in one of two offered Data Interchange Systems (Recipient Verification System-REV or MEDI) for a minimum of one year. The provider must pay for REV; MEDI is free of charge.

Hospital stays and vacations are reported to the Medicaid agency. In the event a SLF does not notify the Medicaid agency of a hosptial stay, the system automatically cancels any payment to the SLF for the period of hospitalization. Once the facility submits notification of the temporary absence using the correct dates of the participant's absence, payment is generated for that time period, provided the participant has available temporary absence days. Any delays in notification are recognized by the payment system and adjustments are made so overpayments are voided or adjusted. The Medicaid agency's Office of Inpector audits this process.

The SLF receives a monthly prepayment report and is under contract to identify and inform the Medicaid agency of any inaccuracies in this report from which the claim is generated. Additionally, a SLF representative must sign a remittance advice that accompanies each payment voucher to verify that the facility accepts the payment amount is correct. The prepayment reports, remittance advice and signature certification documents must be kept on file by the SLF for three years. The Medicaid agency's Office of Inspector General audits these documents.

Monthly capitated rates are paid by the Medicaid agency to the MCOs (Plans). The MCO payment process is automated to generate a monthly capitation to the health plans based on the rate cell of each enrollee 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, per the MCOs' contract with the Medicaid agency, MCOs are required to review their monthly payment and report any discrepancies to the Medicaid agency.

This payment is generated by the MMIS based on participants' eligibility for waiver services as identified in the database system. The Plans only receive payment for individuals eligible for waiver services. 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 enrollee'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 sent on to the State Comptroller for payment. Once the payment has been made by the Comptroller, a file is sent back to HFS by the Comptroller that includes a warrant number and date. HFS then creates a HIPPA 820 file for each MCO. The 820 file contains the detailed payment information on each of the MCO's enrollees.

The Plans are required to have internal processes to validate payments to waiver providers. The Plans' claims processing system must verify an individual's waiver eligibility prior to paying claims.

Post-payment plans of care and financial reviews are also conducted to ensure that plans of care are consistent with needs identified in individuals' assessments. Additionally, the Plans will implement call-in checks for some waiver services to verify a provider was on-site as required during the specified times(s) and post-service verification forms for participants validate they received services.

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:

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:

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.

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:

Supportive living facilities (SLF) may be owned and operated by local housing authorities and local governments. These facilities do not differ from other SLFs in the type or amount of services they provide to waiver participants.

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:*

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.

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. *Select one:*

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.

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:

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:

Room and board rates are determined based on SSI payments available for individuals and couples and are separate from reimbursement by the Medicaid agency for waiver services. Room and board costs are paid directly to the supportive living facility by the waiver participant. These rates increase when SSI amounts increase.

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	17181.12	1473.89	18655.01	22382.72	2489.02	24871.74	6216.73
2	18552.80	1561.27	20114.07	22635.39	2479.26	25114.65	5000.58
3	15330.33	1653.84	16984.17	22890.91	2469.53	25360.44	8376.27
4	15530.43	1751.90	17282.33	23149.31	2459.84	25609.15	8326.82
5	15730.26	1855.77	17586.03	23410.63	2450.18	25860.81	8274.78

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	11700	11700	
Year 2	12600	12600	
Year 3	13000	13000	
Year 4	13400	13400	
Year 5	13800	13800	

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 estimated average length of stay of 235 days for the waiver renewal is based upon CMS-372 lag data for waiver year three of the current waiver.

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 for these estimates is as follows:

Medicaid reimbursement rates for supportive living facilities are calculated at 60% of the average nursing facility rate in each geographic area. An average annual increase of 1.13% is expected for nursing facility costs based claims for WY08-WY12. This same percentage increase has been applied to the average daily rate for the waiver.

The estimated number of waiver participants was derived using State Fiscal Year 2011 waiver participant totals and applying a formula developed by the Medicaid agency to project growth based on the number of new supportive living facility apartments expected each year.

For waiver participants receiving waiver services through a Managed Care Organization (MCO), a capitated rate specific to waiver services is used. The capitation rate will be certified as actuarially sound. The capitation rate will be developed based on historical fee-for-service waiver costs from state fiscal years (SFY) 2008 through 2011. The historical waiver experience will be trended forward to the contract rating years. Further, adjustments will be applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate will also include an administrative and risk load appropriate for the MCO.

Since not all waiver recipients are enrolled in an MCO, Factor D will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

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:

Ancillary service data was pulled for those people with a SLF waiver provider type for WY09-WY12. Factor D Prime is estimated to increase by 5.93% for WY13-WY17. This percentage is basd upon the average historical percentage change for WY09-WY12, actual ancillary expenditures per capita for waiver participants and carried forward to WY13-WY17.

The capitation rate for waiver participants enrolled in Managed Care Organization will include both waiver services, as identified in Factor D, and ancillary medical and pharmacy services. The capitation rate will be certified as actuarially sound. The capitation rate will be developed based on historical fee-for-service costs for ancillary services for waiver recipients from state fiscal years 2008 through 2011. The historical ancillary service expenditures will be trended forward to the contract rating years. Further, adjustments will be applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate will also include an administrative and risk load appropriate for the MCO.

Since not all waiver recipients are enrolled in an MCO, Factor D' will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

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:

Based upon claims of recipients residing in nursing facilities age 60 years and over for WY08-WY12. The estimated WY13-WY17 average per capita has been increased by an estimated 1.13% based upon averages established over previous periods.

For participants receiving nursing facility services through a Managed Care Organization (MCO), a

capitation rate specific to nursing facility services is used. The capitation rate will be certified as actuarially sound. The capitation rate will be developed based on historical fee-for-service nursing facility costs from state fiscal years (SFY) 2008 through 2011. The historical nursing facility experience will be trended forward to the contract rating years. Further, adjustments will be applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate will also include an administrative and risk load appropriate for the MCO.

Since not all nursing facility residents are enrolled in an MCO, Factor G will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

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:

Based upon claims data of ancillary services for actual nursing facility recipients aged 60 years and over for WY08-WY12. The estimated WY13-WY17 average per capita has been increased an estimated 0.78% based upon averages established over previous periods.

The capitation rate nursing facility residents enrolled in Managed Care Organization will include both nursing facility services, as identified in Factor G, and ancillary medical and pharmacy services. The capitation rate will be certified as actuarially sound. The capitation rate will be developed based on historical fee-for-service costs for ancillary services for nursing facility residents from state fiscal years 2008 through 2011. The historical ancillary service expenditures will be trended forward to the contract rating years. Further, adjustments will be applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate will also include an administrative and risk load appropriate for the MCO.

Since not all nursing home residents are enrolled in an MCO, Factor G' will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

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	
Assisted Living	

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
Assisted Living Total:							201019151.25
Assisted Living		day	11700	233.81	73.20	200244236.40	
Assisted Living ICP		day	59	235.00	55.89	774914.85	
Assisted Living MMAI		day	0	0.00	0.01	0.00	
Assisted Living MMAI opt-out		day	0	0.00	0.01	0.00	

GRAND TOTAL:	201019151.25
Total: Services included in capitation:	774914.85
Total: Services not included in capitation:	200244236.40
Total Estimated Unduplicated Participants:	11700
Factor D (Divide total by number of participants):	17181.12
Services included in capitation:	66.23
Services not included in capitation:	17114.89
Average Length of Stay on the Waiver:	235

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 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 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							233765306.23
Assisted Living		day	12600	235.00	74.02	219173220.00	
Assisted Living ICP		day	72	235.00	55.89	945658.80	
Assisted Living MMAI		day	2282	97.36	36.85	8187167.91	
Assisted Living MMAI opt-out		day	1522	90.01	39.85	5459259.52	

GRAND TOTAL:	233765306.23
Total: Services included in capitation:	14592086.23
Total: Services not included in capitation:	219173220.00
Total Estimated Unduplicated Participants:	12600
Factor D (Divide total by number of participants):	18552.80
Services included in capitation:	1158.10
Services not included in capitation:	17395.00
Average Length of Stay on the Waiver:	235

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 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 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							**199294353.12**
Assisted Living		day	13000	168.22	74.86	**163708339.60**	
Assisted Living ICP		day	216	235.00	55.89	**2836976.40**	
Assisted Living MMAI		day	2282	231.10	37.25	**19644539.95**	
Assisted Living MMAI opt-out		day	1522	190.53	45.19	**13104497.17**	

GRAND TOTAL:	**199294353.12**
Total: Services included in capitation:	35586013.52
Total: Services not included in capitation:	163708339.60
Total Estimated Unduplicated Participants:	**13000**
Factor D (Divide total by number of participants):	**15330.33**
Services included in capitation:	2737.39
Services not included in capitation:	12592.95
Average Length of Stay on the Waiver:	235

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 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 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							**208107780.28**

GRAND TOTAL:	**208107780.28**
Total: Services included in capitation:	35589674.58
Total: Services not included in capitation:	172518105.70
Total Estimated Unduplicated Participants:	**13400**
Factor D (Divide total by number of participants):	**15530.43**
Services included in capitation:	2655.95
Services not included in capitation:	12874.49
Average Length of Stay on the Waiver:	235

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living		day	13400	170.05	75.71	172518105.70	
Assisted Living ICP		day	216	235.00	55.89	2836976.40	
Assisted Living MMAI		day	2282	231.21	37.24	19648614.23	
Assisted Living MMAI opt-out		day	1522	191.84	44.88	13104083.94	

GRAND TOTAL:	**208107780.28**
Total: Services included in capitation:	35589674.58
Total: Services not included in capitation:	172518105.70
Total Estimated Unduplicated Participants:	**13400**
Factor D (Divide total by number of participants):	**15530.43**
Services included in capitation:	2655.95
Services not included in capitation:	12874.49
Average Length of Stay on the Waiver:	235

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 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 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							**217077645.77**
Assisted Living		day	13800	171.78	76.56	181490379.84	
Assisted Living ICP		day	216	235.00	55.89	2836976.40	
Assisted Living MMAI		day	2282	231.32	37.22	19647404.77	
Assisted Living MMAI opt-out		day	1522	193.07	44.59	13102884.76	

GRAND TOTAL:	**217077645.77**
Total: Services included in capitation:	35587265.93
Total: Services not included in capitation:	181490379.84
Total Estimated Unduplicated Participants:	**13800**
Factor D (Divide total by number of participants):	**15730.26**
Services included in capitation:	2578.79
Services not included in capitation:	13151.48
Average Length of Stay on the Waiver:	235

Date visited: October 5, 2017