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203 240.1555 General Adult Day Service Staffing Requirements
204 240.1560 Adult Day Service Staff
205 240.1565 Adult Day Service Satellite Sites
206 240.1570 Service Availability Expansion
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208 240.1580 Standards for Alternative Providers
209 240.1590 Standard Requirements for Individual Provider Services (Repealed)
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219 240.1650 Classification, Identification and Receipt of Provider Service Violations
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240 240.1910 Establishment of Fixed Unit Rates
241 240.1920 Contract Specific Variations
242 240.1930 Fixed Unit Rate of Reimbursement for In-home Service
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247 240.1960 Care Coordination Fixed Unit Reimbursement Rates
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254 240.2023 Financial Reporting of Rate-Based Wage Increases for Direct Service Workers
255 240.2030 Unallowable Costs for In-home Service
256 240.2040 Minimum Direct Service Worker Costs for In-home Service
257 240.2050 Cost Categories for In-home Service
258

259 AUTHORITY: Implementing Section 4.02 and authorized by Section 4.01(11) and 4.02 of the
260 Illinois Act on the Aging [20 ILCS 105/4.02 and 4.01].
261
262 SOURCE: Emergency rules adopted at 4 Ill. Reg. 1, p. 67, effective December 20, 1979, for a
263 maximum of 150 days; adopted at 4 Ill. Reg. 17, p. 151, effective April 25, 1980; amended at 4
264 Ill. Reg. 43, p. 86, effective October 15, 1980; emergency amendment at 5 Ill. Reg. 1900,
265 effective February 18, 1981, for a maximum of 150 days; amended at 5 Ill. Reg. 12090, effective
266 October 26, 1981; emergency amendment at 6 Ill. Reg. 8455, effective July 6, 1982, for a
267 maximum of 150 days; amended at 6 Ill. Reg. 14953, effective December 1, 1982; amended at 7
268 Ill. Reg. 8697, effective July 20, 1983; codified at 8 Ill. Reg. 2633; amended at 9 Ill. Reg. 1739,
269 effective January 29, 1985; amended at 9 Ill. Reg. 10208, effective July 1, 1985; emergency
270 amendment at 9 Ill. Reg. 14011, effective August 29, 1985, for a maximum of 150 days;
271 amended at 10 Ill. Reg. 5076, effective March 15, 1986; recodified at 12 Ill. Reg. 7980; amended
272 at 13 Ill. Reg. 11193, effective July 1, 1989; emergency amendment at 13 Ill. Reg. 13638,
273 effective August 18, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 17327, effective
274 November 1, 1989; amended at 14 Ill. Reg. 1233, effective January 12, 1990; amended at 14 Ill.
275 Reg. 10732, effective July 1, 1990; emergency amendment at 15 Ill. Reg. 2838, effective
276 February 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 10351, effective July 1,
277 1991; emergency amendment at 15 Ill. Reg. 14593, effective October 1, 1991, for a maximum of
278 150 days; emergency amendment at 15 Ill. Reg. 17398, effective November 15, 1991, for a
279 maximum of 150 days; emergency amendment suspended at 16 Ill. Reg. 1744; emergency
280 amendment modified in response to a suspension by the Joint Committee on Administrative
281 Rules and reinstated at 16 Ill. Reg. 2943; amended at 15 Ill. Reg. 18568, effective December 13,
282 1991; emergency amendment at 16 Ill. Reg. 2630, effective February 1, 1992, for a maximum of
283 150 days; emergency amendment at 16 Ill. Reg. 2901, effective February 6, 1992, to expire June
284 30, 1992; emergency amendment at 16 Ill. Reg. 4069, effective February 28, 1992, to expire
285 June 30, 1992; amended at 16 Ill. Reg. 11403, effective June 30, 1992; emergency amendment at
286 16 Ill. Reg. 11625, effective July 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg.
287 11731, effective June 30, 1992; emergency rule added at 16 Ill. Reg. 12615, effective July 23,
288 1992, for a maximum of 150 days; modified at 16 Ill. Reg. 16680; amended at 16 Ill. Reg.
289 14565, effective September 8, 1992; amended at 16 Ill. Reg. 18767, effective November 27,
290 1992; amended at 17 Ill. Reg. 224, effective December 29, 1992; amended at 17 Ill. Reg. 6090,
291 effective April 7, 1993; amended at 18 Ill. Reg. 609, effective February 1, 1994; emergency
292 amendment at 18 Ill. Reg. 5348, effective March 22, 1994, for a maximum of 150 days; amended
293 at 18 Ill. Reg. 13375, effective August 19, 1994; amended at 19 Ill. Reg. 9085, effective July 1,
294 1995; emergency amendment at 19 Ill. Reg. 10186, effective July 1, 1995, for a maximum of 150
295 days; emergency amendment at 19 Ill. Reg. 12693, effective August 25, 1995, for a maximum of
296 150 days; amended at 19 Ill. Reg. 16031, effective November 20, 1995; amended at 19 Ill. Reg.
297 16523, effective December 1, 1995; amended at 20 Ill. Reg. 1493, effective January 10, 1996;
298 emergency amendment at 20 Ill. Reg. 5388, effective March 22, 1996, for a maximum of 150
299 days; amended at 20 Ill. Reg. 8995, effective July 1, 1996; amended at 20 Ill. Reg. 10597,
300 effective August 1, 1996; amended at 21 Ill. Reg. 887, effective January 10, 1997; amended at 21
301 Ill. Reg. 6183, effective May 15, 1997; amended at 21 Ill. Reg. 12418, effective September 1,

302 1997; amended at 22 Ill. Reg. 3415, effective February 1, 1998; amended at 23 Ill. Reg. 2496,
303 effective February 1, 1999; amended at 23 Ill. Reg. 5642, effective May 1, 1999; amended at 26
304 Ill. Reg. 9668, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 10829, effective July
305 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17358, effective November 25,
306 2002; emergency amendment at 28 Ill. Reg. 923, effective December 26, 2003, for a maximum
307 of 150 days; amended at 28 Ill. Reg. 7611, effective May 21, 2004; emergency amendment at 30
308 Ill. Reg. 10117, effective June 1, 2006, for a maximum of 150 days; emergency amendment at 30
309 Ill. Reg. 11767, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg.
310 16281, effective September 29, 2006; amended at 30 Ill. Reg. 17756, effective October 26, 2006;
311 amended at 32 Ill. Reg. 7588, effective May 5, 2008; emergency amendment at 32 Ill. Reg.
312 10940, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27,
313 2008; amended at 32 Ill. Reg. 17929, effective November 10, 2008; amended at 32 Ill. Reg.
314 19912, effective December 12, 2008; amended at 33 Ill. Reg. 4830, effective March 23, 2009;
315 amended at 34 Ill. Reg. 3448, effective March 8, 2010; emergency amendment at 34 Ill. Reg.
316 10854, effective July 15, 2010, for a maximum of 150 days; emergency expired December 11,
317 2010; emergency amendment at 34 Ill. Reg. 12224, effective August 4, 2010, for a maximum of
318 150 days; emergency expired December 31, 2010; amended at 35 Ill. Reg. 8919, effective June
319 2, 2011; emergency amendment at 35 Ill. Reg. 13936, effective July 28, 2011, for a maximum of
320 150 days; amended at 35 Ill. Reg. 20130, effective December 6, 2011; emergency amendment at
321 37 Ill. Reg. 11381, effective July 1, 2013, for a maximum of 150 days; emergency expired
322 November 27, 2013; amended at 38 Ill. Reg. 5800, effective February 21, 2014; amended at 38
323 Ill. Reg. 14230, effective June 25, 2014; amended at 41 Ill. Reg. 15233, effective January 1,
324 2018; recodified at 42 Ill. Reg. 817; amended at 42 Ill. Reg. 20653, effective January 1, 2019;
325 amended at 44 Ill. Reg. 2780, effective January 29, 2020; amended at 44 Ill. Reg. 5995, effective
326 April 3, 2020; amended at 44 Ill. Reg. 8609, effective May 13, 2020; amended at 45 Ill. Reg.
327 13819, effective October 21, 2021; amended at 46 Ill. Reg. 12492, effective July 1, 2022;
328 emergency amendment at 47 Ill. Reg. 7115, effective May 10, 2023, for a maximum of 150 days;
329 emergency expired October 6, 2023; emergency amendment at 47 Ill. Reg. 15675, effective
330 October 18, 2023, for a maximum of 150 days amended at 48 Ill. Reg. 1129, effective January 3,
331 2024; amended at 48 Ill. Reg. ______, effective ____________.
332
333 SUBPART A: GENERAL PROGRAM PROVISIONS
334
335 **Section 240.160 Definitions**
336
337 "Adequate person-centered plan of care" means a person-centered plan of care
338 that provides the minimum services needed to protect the health, safety and
339 welfare of a participant.
340
341 "Adjusted rate" means a rate other than the established fixed rate of
342 reimbursement.
343
344 ~~"Administrative corrections" means allowable revisions to a proposal permitted~~

345 ~~and/or performed by the Department in cases of apparent clerical mistakes and in~~
346 ~~cases where the participant/Department has reason to believe a mistake may have~~
347 ~~been made and verification from the participant has been provided. These actions~~
348 ~~shall be taken prior to award.~~
349
350 "Administrative costs" means those allowable costs related to the management
351 and organizational maintenance of the provider.
352
353 "Adverse action" means the denial of CCP service; a reduction in dollars in the
354 monthly cost of care according to the Participant Agreement – Person-Centered
355 Plan of Care; a change in service type that could increase the participant's
356 incurred monthly expense for care prior to July 1, 2010; or the termination from
357 CCP service.
358
359 "Allegations" means unsubstantiated accusations or statements.
360
361 "Allowable costs" means those cost categories, as delineated in Section 240.2050,
362 which will be considered in setting a fixed rate.
363
364 "Allowable maximums" means the highest authorized allocation available for
365 services per month based upon Determination of Need assessment tool scores or
366 the corollary scores on any successor assessment tool authorized by the
367 Department to determine need for long term services and supports.
368
369 "AMD" means automated medication dispenser.
370
371 "Appellant" means the participant/authorized representative initiating an appeal as
372 a result of Department action or inaction.
373
374 ~~"Assistance with task" means giving aid or support in the performance of a task.~~
375
376 "Assistive device" means crutches, walker, wheel chair, hearing aid, etc.
377
378 "Authorized representative" means an agent designated, verbally or in writing, by
379 the participant to be his/her representative, or the participant's legal guardian. In
380 the event that a participant is unable to physically write his/her signature, the
381 CCU may sign for the participant at the participant's verbal request.
382
383 "Authorized representative of the provider" means an owner, officer, or employee
384 of the provider agency who has the authority to commit the agency to a financial
385 and/or contractual responsibility.
386
387 "Authorized provider" or "provider" means a provider who holds a valid contract

388 with the Department to provide Community Care Program (CCP) services. CCP
389 services are provided on a reimbursement basis for units of service delivery to
390 specified participants.
391
392 "Available resources" means assistance provided to a participant by
393 family/friends, church, community, etc.
394
395 "Best interest" means the determined needs of the participant population are being
396 met.
397
398 "Burial merchandise" means gravesites, crypts, mausoleums, urns, caskets, vaults,
399 grave markers or other repositories for the remains of deceased persons, shrouds,
400 etc.
401
402 "Calendar year" means from January 1 through December 31.
403
404 "Capable person" means a person who is qualified to perform the functions
405 required.
406
407 "Care Coordinator" means a trained individual who is employed to assess needs,
408 conduct eligibility screenings, and perform care coordination services and care
409 coordination functions under the Community Care Program.
410
411 "CCP" means Community Care Program.
412
413 "CCU" means Care Coordination Unit.
414
415 ~~"CCU in good standing" (See: Contractor in good standing)~~
416
417 "Certified Public Accountant" or "CPA" means a person licensed or authorized to
418 practice accounting under the Illinois Public Accounting Act [225 ILCS 450].
419
420 "Choices for Care" means a CCP program under which CCUs conduct
421 prescreening or postscreening assessments to determine eligibility of participants
422 age 60 and over for nursing facility placement, supportive living program
423 placement, or the choice of community-based services. Screenings may be
424 conducted in a hospital, nursing facility, supportive living program, or in the
425 community depending on the circumstances.
426
427 "Close-out review" means a review performed at the close of the period of time
428 allowed for correction of findings of non-compliance to determine if those
429 corrections have been made and that the newly drawn review sample of
430 participant/provider files reflects on-going compliance.

~~"Closed caseload" means a caseload restricted to those participants already receiving service and refers only to individual providers; no new participants shall be accepted and current participants who discontinue service for any reason will not be reinstated into this caseload.~~

"Community-based services" means services provided in an integrated setting in a participant's community.

"Comparable human service program" means a program that offers services that are similar to CCP services (e.g., home health aide, maid service).

"Compliance" means adherence to the CCP rules, policy and procedures and the contract with the Department, and all applicable federal, State and local laws/rules/ordinances.

"Components" means specified parts of the service as defined in the applicable Section.

"Confused and disoriented" means unable to clearly and accurately differentiate as to time, person and/or place.

"Continuous eligibility" means that the participant has met eligibility requirements each time a subsequent redetermination was administered.

~~"Contractor in good standing" means a CCP contractor who is currently in compliance or within the permitted time frame allotted for remedy to come into compliance with the Department's rules and contract.~~

~~"Control date" means a starting point for purposes of calculating a time frame; the count begins the next work or calendar day.~~

"Cost report" means a report of all categorized allowable costs to a provider that are directly associated with services purchased by the Department for its participants in categories as defined in Section 240.2050. The provider shall use the Direct Service Worker Cost Certification and the Detailed Cost Certification forms.

"Critical event" means any actual or alleged incident or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a participant. There are three~~3~~ subcategories that will be reported to the Department:

474 "Critical Incidents" include anticipated death, unanticipated death,
475 hospitalization, medication error, serious injury, missing person,
476 emergency department visit, property damage, nursing facility placement,
477 fall (with injury), fall (without injury), special circumstance, criminal
478 activity, and law enforcement interaction;
479
480 "Service Improvement Program Complaints" or "SIPs" is a complaint
481 based reporting process with the purpose of identifying and resolving
482 problematic issues related to the provision of home and community based
483 services (HCBS); and
484
485 "Request for Change of Status" occurs anytime the condition of a CCP
486 participant changes or there is a change in circumstances that affect the
487 ability of the family and/or caregiver to safely provide support and
488 assistance.
489
490 ~~"Daily census maximum" means the total square footage of adult day service~~
491 ~~participant-allotted space divided by 40 sq. ft. equals the daily maximum number~~
492 ~~of participants that may be served in the adult day service facility.~~
493
494 "Department" means the Illinois Department on Aging.
495
496 "Director" means the Director of the Illinois Department on Aging.
497
498 "Discontinuance" means the cessation of CCP services provided to a participant
499 for non-payment of incurred expense for care prior to July 1, 2010.
500
501 "Documentation" means tangible documents or supporting references or records
502 used to record participant contact, determine eligibility or substantiate adherence
503 to rules.
504
505 "Documenting" means making written and/or electronic entries on the Case
506 Record Recording Sheet regarding contact with a participant; and/or the viewing
507 or receiving of a document to be placed in participant /worker files to substantiate
508 adherence to rules.
509
510 "DON" means the Determination of Need, which is a component of the
511 comprehensive assessment tool, or any successor assessment tool authorized by
512 the Department, used to determine CCP eligibility under this Part.
513
514 "EHRS" means emergency home response service.
515
516 "Emergency" means a sudden unexpected occurrence demanding immediate

action (e.g., participant illness, illness/death of a member of the participant's family).

~~"Emergency home response service" or "EHRS" means a 24-hour emergency communication link to assistance outside the participant's home based on the participant's health and safety needs and mobility limitations. This service is provided by a 2-way voice communication system consisting of a base unit and an activation device worn by the participant that will automatically link the participant to a professionally staffed support center. The support center assesses the situation and directs an appropriate response whenever this system is engaged by a participant.~~

"Errands" means performance of services outside the home such as essential shopping, picking up medications, and essential business needs as indicated in the person-centered plan of care.

"Escort" means accompanying those participants who are dependent on personal physical assistance to enable them to reach and use community resources in order to ensure their access to local services and to allow them to maintain independent living as required by the person-centered plan of care.

"Essential" means basic, indispensable or necessary.

~~"Exit conference" means the meeting at the Illinois Department on Aging between representatives of the Department and the Director, or his/her designee, and of the reviewed agency to resolve the agency's objection to the findings of the Compliance Review Report. These conferences shall be called when the findings indicate evidence of serious participant-related concerns (e.g., Type I findings).~~

"Extraordinary care" means care provided by a legally responsible individual: that exceeds what would ordinarily be provided to a person of the same age without a disability or chronic condition, and is necessary to assure the health and welfare of the participant and avoid institutionalization, as documented by the Care Coordination Unit; in instances when the CCU documents there are no other qualified homecare aides available to provide the services required under the participant's person-centered plan of care; or in instances when the CCU documents the legally responsible individual has a unique ability to meet the needs of the participant, and services provided by the legally responsible individual are in the best interest of the participant.

"Face-to-face" means direct communication while physically in the presence of another person or persons.

560 "Face-to-face review" means an informal review (see Section 240.425) conducted
561 in the appeal process by the Department in the home of an appellant with the
562 participant (and appellant, if appellant is other than the participant) present.~~ (A~~
563 ~~hearing is conducted by a Hearing Officer – see Section 240.450.)~~
564
565 "FUTA" means the Federal Unemployment Tax Act.
566
567 "Fiscally sound agency" means a CCU or provider that has on file at the
568 Department documentation that supports that the CCU or provider has adequate
569 financial resources to perform the terms of the contract (e.g., a line of credit from
570 a financial institution).
571
572 "Fraudulent information" means purposely erroneous or untruthful information.
573
574 "Geographic area" means a physical area (e.g., county) of the State within which a
575 contractor is authorized to provide services to Community Care Program
576 participants.
577
578 "Good standing" means a provider or CCU who is currently in compliance or
579 within the permitted time frame allotted for remedy to come into compliance with
580 the Department's rules and contract.
581
582 ~~"Historical costs" means the total allowable costs incurred for all programs the~~
583 ~~provider provided for the previous reporting year, which are presented via~~
584 ~~certified report by the provider.~~
585
586 "Home maintenance and repairs" means those non-routine tasks, excluding any
587 work requiring a ladder or requiring specialized skills on the part of the worker,
588 necessary to maintain a safe and healthful environment for the participant as
589 required by the person-centered plan of care (e.g., defrosting the refrigerator;
590 cleaning the oven; dusting walls and woodwork; cleaning closets, cupboards and
591 insides of windows; changing filters on and cleaning humidifiers; replacing light
592 bulbs; clearing hazards from outside steps and sidewalks if transportation and/or
593 escort is required by the person-centered plan of care).
594
595 "Imminent" means likely to occur (e.g., injury or nursing facility care).
596
597 ~~"Incomplete proposal" means the written offer to the Request for Proposal (e.g.,~~
598 ~~attachments, appendices) that fails to include all requirements as stated in the~~
599 ~~Request for Proposal.~~
600
601 "Incurred monthly expense" means the participant's share of the cost of care for
602 CCP services provided during a previous monthly period prior to July 1, 2010.

603
604 "Informal review" means the act of determining the facts relating to an appeal in
605 an informal manner by the Department. ~~(see Section 240.425).~~
606
607 "Informality" means an irregularity that is a matter of form or variation from the
608 exact requirement of the Request for Proposal, the correction or waiver of which
609 would not be prejudicial to other applicants (e.g., failure to return number of
610 copies of signed proposals as required by the Request for Proposal).
611
612 "In-home services" means services provided in the participant's residence with the
613 participant present or on behalf of the participant (e.g., homecare aide).
614
615 ~~"Intermediate Care Facility" or "ICF" means a facility that provides basic nursing~~
616 ~~care and other restorative services under periodic medical direction. Many of~~
617 ~~these services may require skill in administration. ICFs are for residents who have~~
618 ~~long term illnesses or disabilities that may have reached a relatively stable~~
619 ~~plateau.~~
620
621 "Legal guardian" means an individual who has been appointed guardian of
622 another adult by a court.
623
624 "Legally Responsible Individual" or "LRI" means any individual who has a legal
625 duty to provide care for a participant and includes the participant's spouse, power
626 of attorney (medical, legal, or financial), or representational payee who is hired by
627 a CCP in-home service provider to deliver extraordinary care to a CCP
628 participant. An LRI is not an alternative provider as described in 240.270 or a
629 legal guardian.
630
631 "Licensed Practical Nurse" or "LPN" means a person licensed to practice practical
632 nursing under the Nurse Practice Act [225 ILCS 65].~~nurse who has graduated~~
633 ~~from a formally approved program of practical nursing education and has been~~
634 ~~licensed by the appropriate State authority.~~
635
636 "Mandated time period" means the time frame required by pertinent rule.
637
638 ~~"M.D." means medical doctor who is registered in the State of Illinois.~~
639
640 "Memorandum of Understanding" or "MOU" means a written document, executed
641 by the participant/authorized representative, CCU representative and provider
642 representative in which all parties agree to cooperate and in which activities are
643 specified that must be fulfilled by each party.
644
645 "Observing participant's functioning" means watching for any change in the

participant's needs that could indicate that a redetermination of eligibility and/or a revision in the CCP Participant Agreement – Person-Centered Plan of Care is necessary (e.g., participant is experiencing increasing difficulty in walking; participant is becoming increasingly confused and disoriented; participant's family member is no longer available to prepare meals for the participant).

"Occupancy costs" means the costs of depreciation, amortization of leasehold improvements, rent, property taxes, interest and other related costs.

"On-Notice" means the Department sanction imposed on a provider or CCU requiring that provider or CCU to bring specified services or requirements into compliance.

~~"Parent organization" means an entity to which the contractual party is a subsidiary.~~

"Participant" means a person who made a request for services, receives services, or is appealing benefits decisions under the Community Care Program.

~~"Performance of task" means to carry out an action, function or process.~~

~~"Period of stay" means period of time during which implementation of a contract action is temporarily delayed.~~

"Person-centered planning" means that service planning for participants in the Persons who are Elderly Waiver shall be developed through a person-centered planning process that addresses health and long-term services and supports (paid and unpaid) needs in a manner that reflects participant personal preferences, choices and goals. The person-centered planning process is directed by the participant and may include an authorized representative that the participant has freely chosen to contribute to the process. The planning process, and the resulting person-centered plan of care, will assist the participant in achieving personally defined outcomes in the most integrated community setting, including the assurance of their health, safety and welfare.

"Physician" or "MD" means a person licensed to practice medicine in all of its branches under the Medical Practice Act of 1987 [225 ILCS 60].

"Planning and Service Area" or "PSA" means a designated geographic area.

"Post-screening" means screening performed after a participant has entered a nursing facility due to an emergency situation or oversight without prescreening.

"Potentially" means having the capability of occurring, but not yet in existence (e.g., deterioration in the participant's condition).

"Program support costs" means those allowable costs not included as direct service or administrative costs.

"Proposal" means the written offer made by an applicant in response to Department Request for Proposal.

"Provider certification" means a provider has a valid contract with the Department.

"Provider Agreement" means purchase of service agreement.

~~"Provider community experience" means documentation of having provided service within the community in which the provider has applied to provide CCP services.~~

~~"Provider in good standing" (See: Contractor in good standing)~~

~~"Providers" means those service providers with whom the Department does business through contracts on a reimbursement basis for units of service delivery to specified participants.~~

"Reasonable" means using and showing reason or sound judgement, sensible, not excessive.

"Reasonable and diligent effort" means perseverance on the part of the participant/client in his/her attempt to dispose of the asset (e.g., as evidenced by copies of the advertisement for the sale of the asset).

"Registered Nurse" or "RN" means a person licensed to practice nursing under the Nurse Practice Act [225 ILCS 65].~~nurse who has graduated from a formal program of nursing education and has been licensed by the appropriate state authority.~~

"Reinstatement" means the resumption of services, within an established time frame, at the same level provided prior to a suspension/discontinuance of the services.

"Related parties" means any other entities having a legal or contractual relationship with the contractual party.

"Request for Proposal" or "RFP" means a form of invitation to bid that the Department uses to obtain care coordination services and demonstration/research projects under the CCP. The RFP explains the purpose of the invitation to bid, outlines the scope of the work and solicits proposals from provider agencies for the funding of services undertaken by the Department.

"Responsible person" means a capable person who does not appear to be disoriented or confused and is presumed to be acting in the best interest of another individual.

"Risk mitigation" means the process in which events or experiences that place the health, welfare and safety of program participants in jeopardy are evaluated in terms of nature, frequency and circumstance with the intent of providing services and supports aimed at reducing risk and the likelihood of its reoccurrence.

"Rotation plan" means a Department approved plan for the equitable distribution of participants to providers (used only if participant does not indicate a choice of providers).

"Routine procedures" means procedures performed in a hospital that result in no perceptible change in the participant's physical/mental health needs (e.g., tests, blood work-ups, x-rays, dialysis).

"Service area" means any area in which a provider has been awarded a contract to provide CCP services.

~~"Skilled Nursing Facility" or "SNF" means a group care facility licensed by the Illinois Department of Public Health that provides skilled nursing care, continuous skilled nursing observations, restorative nursing and other services under professional direction with frequent medical supervision. SNFs are provided for patients who need the type of care and treatment required during the post-acute phase of illness or during reoccurrences of symptoms in long-term illness (89 Ill. Adm. Code 101.20).~~

"Special diet" means a dietary restriction based upon the health and safety needs of the participant and prescribed by a physician (e.g., sodium free, fat, protein, diabetic, etc.); whereas a modified diet relates to a diet containing easy to chew foods. A modified diet may be part of a specialized diet.

"State fiscal year" means from July 1 through June 30.

"Supportive Living Program" or "SLP" means the program that provides an affordable assisted living model offering limited personal and health services

775 integrated within apartment-style housing. The SLP operates under the authority
776 of a 1915(c) ~~Home and Community Based Services (~~HCBS~~)~~ Waiver. The SLP
777 serves persons who would otherwise need nursing facility (NF) care, but whose
778 individual needs can be met by the SLP. HFS is the operating agency for the SLP
779 Waiver.
780
781 "Suspension" means the temporary cessation of the provision of Community Care
782 Program services provided to a participant.
783
784 "Suspension of referrals" means closed intake of new participants to a specific
785 contractor.
786
787 "Termination" means the permanent cessation of the provision of Community
788 Care Program services and eligibility of services.
789
790 "Threat" means the existence of circumstances that indicate the intent of an
791 individual or group to destroy the property of or to injure or punish another
792 individual or group, or the display of a weapon at an adult day services center or
793 home.
794
795 "Too highly impaired participant" means a participant who needs 24 hour a day
796 care, for whom CCP cannot develop a person-centered plan of care to protect
797 his/her physical, mental and environmental needs and who does not have
798 sufficient outside support from family, friends, church et. al., to provide for those
799 needs (as determined by Part B – Unmet Need for Care – of the Community Care
800 Program – Determination of Need). (Refer to Section 240.715.)
801
802 "Unallowable costs" means those costs that will not be considered in determining
803 the fixed rate or in meeting the required minimum direct service expenditure.
804
805 "Unit of service" means a measured length of service, such as an hour, a day, a
806 visit, a one-way trip, or some other measurable service component that will enable
807 the Department to determine the amount of service provided individually or in
808 aggregate to or on behalf of a participant.
809
810 ~~"Validation of provider community experience" means the documentation of~~
811 ~~letters from community agencies attesting to experience with the provider within~~
812 ~~the community.~~
813
814 ~~"Validity of participant billing" means the accuracy of the billing and~~
815 ~~documentation for participant services.~~
816
817 "Work days" means Monday through Friday at a minimum, excluding provider

818 designated holidays.
819
820 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
821
822 **Section 240.170 Variance**
823
824 The Director may grant variances from this Part in individual cases when they find that:
825
826 a) The provision from which the variance is granted is not statutorily mandated;
827
828 b) No party will be injured by the granting of the variance; and
829
830 c) The provision from which the variance is granted would, in the particular case, be
831 reasonable or unnecessarily burdensome.
832
833 (Source: Added at 48 Ill. Reg. ______, effective ____________)
834
835 SUBPART B: SERVICE DEFINITIONS
836
837 **Section 240.210 In-home Service**
838
839 In-home service is defined as general non-medical support by supervised homecare aides who
840 have received specialized training in the provision of in-home services. The purpose of
841 providing in-home service is to maintain, strengthen and safeguard the functioning of
842 participants in their own homes in accordance with the authorized person-centered plan of care.
843
844 a) Specific service components of in-home service shall include the following:
845
846 1) Teaching/performing of meal planning and preparation; light
847 housekeeping tasks (e.g., making and changing beds, dusting, washing
848 dishes, vacuuming, cleaning floors, keeping the kitchen and bathroom
849 clean and laundering the participant's linens and clothing); shopping
850 skills/tasks; and home maintenance and repairs.
851
852 2) Performing/assisting with essential shopping/errands may include
853 handling the participant's money (proper accounting to the participant of
854 money handled and provision of receipts are required). These tasks shall
855 be:
856
857 A) performed as specifically required by the person-centered plan of
858 care; and
859
860 B) monitored by the homecare supervisor.

3) Assisting with self-administered medication, which shall be limited to:

A) reminding the participant to take his/her medications;

B) reading instructions for utilization;

C) uncapping medication containers; and

D) providing the proper liquid and utensil with which to take medications.

4) Assisting with following a written special diet plan and reinforcement of diet maintenance (can only be provided under the direction of a physician as required by the person-centered plan of care).

5) Observing participant's functioning and condition and reporting to the supervisor, as outlined by the person-centered plan of care.

6) Performing/assisting with personal care tasks that are not medical in nature, such as the examples set forth at 77 Ill. Adm. Code 245.40(c) (e.g., shaving, hair shampooing, drying and combing, bathing and sponge bath, shower bath or tub bath, toileting, dressing, nail care, respiratory services ~~(as authorized by 20 ILCS 105/4.02(5)(F))~~, brushing and cleaning teeth or dentures and preparation of appropriate supplies, positioning/transferring participant, and assisting participant with exercise/range of motion), as defined by the person-centered plan of care.

7) Escort/transportation to medical facilities, or for essential errands/shopping, or for essential participant business with or on behalf of the participant, as defined by the person-centered plan of care. This escort/transportation service may be provided directly by the homecare aide, directly by the provider, by the provider through contract, or by public transportation.

8) Identifying and reporting critical events, including critical incidents, service improvement program complaints, and requests for change of status in the Department's automated reporting system. Completing initial critical event reports will occur within seven~~7~~ days after the date the event occurred or was identified to have occurred. Assisting CCUs in their efforts to safeguard participant health, safety and welfare by demonstrating a willingness to collaborate, discuss and resolve issues that likely place a participant at increased risk for experiencing future critical

events. Supporting CCU risk mitigation efforts by demonstrating a willingness to communicate about necessary adjustments to a participant's care plan in response to a critical event.

b) Unit of Service

1) One unit of in-home service is one hour of direct service provided to the participant in the participant's home, while providing transportation/escort, or while running errands and/or shopping on behalf of the participant.

2) Refer to Section 240.1930 for further information regarding reimbursement.~~For services that the provider was unable to provide due to either the participant's absence without prior provider notification or refusal to admit the worker into the home to provide service (see Section 240.350), one unit of documented in-home service per occurrence will be reimbursed to the provider at a maximum of 2 units per participant per State fiscal year.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.230 Adult Day Service (ADS)

Adult day service is the direct care and supervision of adults aged 60 and over in a community-based setting for the purpose of providing personal attention and promoting social, physical and emotional well-being in a structured setting. These services shall be provided pursuant to an ADS Addendum to the participant's person-centered plan of care.

a) Required Service Components

1) Assessment of the participant's strengths and needs and development of an individual written person-centered plan of care for each participant that establishes specific participant goals for all service components to be provided or arranged for by the service provider.

A) The individual ADS Addendum will be developed by the adult day service team consisting of participant/authorized representative, Program Coordinator/Director and Program Nurse, and may include other staff at the option of the program Coordinator/Director.

B) The participant, caregiver and other service providers will have the opportunity to contribute to the development, implementation and evaluation of the individualized ADS Addendum.

C) The individualized ADS Addendum is to be established not later than the fourth week of service.

D) The individualized ADS Addendum shall address the needs identified by the CCU, as described in the comprehensive assessment.

E) The individualized ADS Addendum to the person-centered plan of care shall address the need identified by the service provider's staff and participant/authorized representative/caregiver during the individualized ADS Addendum process.

F) Reassessing the participant's needs and reevaluating the appropriateness of the individualized person-centered plan of care shall be done as needed, but at least annually.

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

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

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

C) Activity opportunities shall be available whenever the service provider's facility is in operation and participants are in attendance.

D) A monthly calendar of activities shall be prepared and posted in a visible place.

E) Opportunities to participate in other activities outside of the ADS shall be provided. The setting will be integrated in, and support access to, the greater community.

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

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

5) Provision of a daily meal that meets the Dietary Guidelines for Americans, 2020-2025, 9th~~2015-2020, 8th~~ edition, published by the Secretary of Health and Human Services and the Secretary of Agriculture; and that provides each participant a minimum of 33.5% of the Dietary Reference Intakes (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Supplementary nutritious snacks shall also be provided. Special diets shall be provided as directed by the participant's physician.

6) Agency provision or arrangement for transportation, with at least one vehicle physically accessible, to enable participants to receive adult day service at the adult day service provider's site and participate in sponsored outings.

7) Provision of emergency care as appropriate in accordance with established adult day service provider policies and Section 240.1510.

8) Identifying and reporting critical events including critical incidents, service improvement program complaints, and requests for change of status in the Department's automated reporting system. Completing initial critical event reports will occur within seven~~7~~ days after the date the event occurred or was identified to have occurred. Assisting CCUs in their efforts to safeguard participant health, safety and welfare by demonstrating a willingness to collaborate, discuss and resolve issues that likely place a participant at increased risk for experiencing future critical events. Supporting CCU risk mitigation efforts by demonstrating a willingness to communicate about necessary adjustments to a participant's person-centered plan of care or ADS Addendum in response to a critical event.

b) Ancillary Service Components

1) Ancillary services, including physical, occupational, speech and creative arts therapies may be provided by site staff or through contractual arrangements when needed by participants. If provided, ancillary services

shall be within the framework of the individualized person-centered plan of care and ADS Addendum and shall be in accordance with professional practice standards and applicable State and federal regulations.

2) Skilled nursing services, including, but not limited to, catheter installation, irrigations and care, dressings, enemas, oxygen therapy, suction/posturing, ostomy care and restorative nursing such as bladder retraining. (All these procedures/interventions require physician orders and shall be administered by a Registered Nurse or a Licensed Practical Nurse, in accordance with the Illinois Nurse Practice~~Nursing~~ Act [225 ILCS 65].)

3) Shopping assistance.

4) Escort to medical and social services.

5) ~~AGENCY NOTE:~~ Reimbursement for costs of ancillary services is not included in the unit rate paid by the Department and will not be paid by the Department.

c) Unit of Service

1) One unit of ADS~~adult day service~~ is defined as one direct participant contact hour (excluding transportation time) provided to a participant. A direct participant contact hour is defined as 60 consecutive minutes of active programming, i.e., providing one or a combination of the service components listed in subsections (a)(2) through (7).

2) One unit of documented ADS~~adult day service~~ transportation, provided by the ADS~~adult day service~~ provider, is defined as a one-way trip per participant to or from the adult day service provider's site and the participant's home. No more than two units of transportation shall be provided per participant in a 24-hour period, and shall not include trips to a physician, shopping, or other miscellaneous trips.

~~3) For services (including transportation, if specified in the individualized ADS Addendum) which the provider was unable to provide due to the participant's absence without prior notification (see Section 240.350), the provider shall be reimbursed as follows:~~

~~A) Two and one half units of documented adult day service per occurrence to a maximum of 5 units per participant per State fiscal year.~~

~~B) One unit of documented adult day service transportation, provided by the adult day service provider, per occurrence to a maximum of 2 units per participant per State fiscal year.~~

3~~4~~) Refer to Section 240.1950 for further information regarding reimbursement.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.235 Emergency Home Response Service

a) Service Definition
Emergency home response service (EHRS) is defined as a 24-hour emergency communication link to respond to emergent participant needs. EHRS~~assistance outside the participant's home based on the participant's health and safety needs and mobility limitations. This service~~ is provided by a two-way~~2-way~~ voice communication system which may consist~~consisting~~ of a base unit~~ and an activation device worn by the participant~~ that can be activated using landline, cellular, and/or internet-based access and a water-resistant activation device worn by the participant that will automatically link the participant to a professionally staffed support center. When the system is engaged by a participant, the~~The~~ support center shall assess~~assesses~~ the situation and direct~~directs~~ an appropriate response~~ whenever this system is engaged by a participant~~. EHRS equipment shall include a variety of remote or specialty activation devices from which the participant can choose in accordance with their specific need as outlined in their authorized person-centered plan of care.~~The purpose of providing EHRS is to improve the independence and safety of participants in their own homes in accordance with the authorized person-centered plan of care, and thereby help reduce the need for nursing facility care.~~

b) A EHRS provider shall provide the participant with a base unit, when it is required for the equipment to function, and an activation device with all connectors, parts and equipment necessary for installation.~~Specific components of EHRS shall include the following:~~

c) A participant may choose an activation device capable of sensing at least a 36-inch drop when the participant has fallen and automatically alerting the support center for assistance.

d) A participant may choose to switch from the standard activation device to a mobile device that is not connected to a landline and that is capable of providing the support center with the participant's latest location using GPS. The device must allow for two-way interactive communication and include an optional all-in-

one device. The device must have at least a five-day battery life, depending on usage, and be compatible with a fall detection device if the participant so chooses.

e) The activation device shall be adaptive for participants with functional limitations (visual, audio, physical, etc.). These devices shall be provided at no extra cost to the participant.

f) A participant shall inform their EHRS provider if they are away from home for longer than 30 consecutive calendar days. A participant who resides outside of the State for more than 60 calendar days may lose eligibility to received EHRS services and may have their services terminated.

~~1) provide a base unit and, when necessary, adaptive activation devices, together with all connectors, parts and equipment necessary for installation, that can be used in a home by up to 2 participants with hearing, mobility and/or visual impairments.~~

~~A) Wireless adaptive activation devices (e.g., sip and puff, rocking lever switch) must be available when a participant cannot physically activate the call button.~~

~~B) The system must be useable by visually and hearing impaired participants through visual and audible indications of alarm activation.~~

~~C) Adaptive activation devices shall be provided at no extra cost to the participant;~~

g) An EHRS provider shall:

1~~2~~) deliver and install the EHRS equipment~~activation device~~ to the participant ~~and install the base unit, including connection of a seizure line jack, into a functioning telephone system in the participant's home~~ within 15 calendar days after the date of referral. This service shall not be subcontracted and shall be completed by trained employees who must have identification that they work for the EHRS provider~~identified by picture ID with an ID number that can be verified by the participant~~;

2~~3~~) train the participant and their~~his or her~~ designated emergency contacts~~responders~~ on the proper use of the equipment~~base unit and activation device~~ at the time of installation and provide easy to use written instructions on how to use the equipment. Instructions must be provided in

a language or format easiest for the participant to use;~~. The training must include:~~

~~A) demonstration of use and maintenance of EHRS equipment;~~

~~B) explanation of the EHRS provider's services and response protocol;~~

~~C) information on the general care of the base unit and activation device;~~

~~D) instruction about the monthly testing of the base unit and how to transmit the test results to the support center; and~~

~~E) providing the participant with easy to understand written instructions in the use of EHRS devices, including how to report a malfunction of the equipment. These instructions shall also be available in Braille or tape recorded to meet the participant's needs;~~

3~~4~~) assist the participant in selecting and designating up to three~~3~~ local emergency contacts~~responders~~, which must be updated by the EHRS provider at least every six~~6~~ months. Each contact~~responder~~ shall receive both verbal and written instructions from the provider;

4~~5~~) obtain participant's/authorized representative's signature to document that the EHRS equipment~~unit~~ was delivered and installed and that instructions and demonstration were given and understood. A copy of this receipt must be sent to the CCU;

5~~6~~) have~~own and operate~~ a support center to provide live monitoring on a continuous basis, direct an appropriate response whenever the EHRS system is activated, and provide necessary technical support for fault conditions, including a language line that provides interpreter service for ~~at least 140~~ languages most commonly spoken by older adults in the state and communication facilitated by a teletypewriter (TTY) communication device for the deaf, as appropriate;

6~~7~~) have~~own and operate~~ a back-up support center that provides all components specified in subsection (e~~b~~)(5~~6~~) and operates on a separate power grid;

7~~8~~) maintain adequate local staffing levels of qualified personnel to service necessary administrative activities, installation, in-home training, signal monitoring, technical support and repair requests in a timely manner. A provider agency must have a ~~written~~ training program for personnel and be able to demonstrate staff qualifications;

8~~9~~) in the event of a malfunction, repair or replace the base unit or activation device within 24 hours after receiving the malfunction report;

9~~10~~) alert the participant when electric power to the base unit has been interrupted (e.g., unplugged) and the unit is operating on a standby power source;

10~~11~~) notify the CCU within one~~1~~ business day after activation of the base unit and work with the appropriate care coordination supervisor to resolve service complaints from the participant or emergency responder;

11~~12~~) notify the CCU immediately if EHRS services cannot be initiated or must be terminated; and

12~~13~~) maintain records in accordance with Section 240.1542 relating to participant referral and service statistics, including equipment delivery; device activation; participant and responder training; signal monitoring and test transmission activity; equipment malfunction, repair and replacement; power interruption alerts; and notification of the CCUs, plus billing and payment information, and personnel matters.

h~~e~~) Units of Service

1) One unit of installation service is the one-time fee to the EHRS provider ~~agency~~ for the activity associated with the installation of the base unit in the participant's home.

2) One unit of monthly service is the fixed unit rate of reimbursement, per month, for the EHRS provider ~~agency~~ activity associated with providing EHRS to each participant.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.237 Automated Medication Dispenser Service

a) Service Description

1) AMD service is defined as a portable, mechanical system for individual use that can be programmed to dispense or alert the participant to take non-liquid oral medications through auditory, visual or voice reminders; to provide notification of a missed medication dose; and to provide 24-hour technical assistance for the AMD service in the participant's residence. The service may include medication specific directions or reminders to take other types of medications such as liquid medications or injections based on individual need. The AMD unit is connected to a Department approved support center through a telephone line or wireless/cellular connection in the participant's residence.

2) The purpose of the service is to provide eligible participants with medication reminders to foster timely and safe administration of a medication schedule, thereby promoting independence and safety of all participants in their own residence, as well as reducing the need for nursing home care.

3) The authorization to receive this service is determined by the care coordinator through a screening process set forth in Section 240.741, which requires the participant/authorized representative to designate an assisting party to manage the AMD unit and medications.~~ as set forth in Section 240.741.~~

4) The Department does not perform medication management, oversight or handling of the participant's medications.

5) Provision of this service is contingent upon it continuing to be an approved service under the HCBS Waiver for Persons Who are Elderly.

b) Specific components of AMD service must include, at a minimum, the following:

1) an AMD unit installed in the participant's residence with all connectors, parts and equipment necessary for installation, and adaptations for operation by individuals who have functional, hearing or visual impairments, or who exhibit language barriers.

2) delivery of the AMD unit to the participant and installation of the unit within 48 hours after the referral when the participant is at imminent risk of institutionalization and within 15 calendar days from the date of the referral in all other instances.

A) This timeline can be extended if requested by the participant/authorized representative/assisting party.

B) This service shall not be subcontracted and shall be provided by trained employees who will identify themselves by picture identification that can be verified by the participant/authorized representative/assisting party.

C) Delivery and installation of the AMD unit may include coordination of EHRS~~emergency home response service (see Section 240.235)~~ for a participant.

D) Provider shall make every effort to schedule and conduct the installation when the participant, authorized representative (if applicable), and assisting party are present. Documentation of such efforts shall be provided to the Department upon request.

3) training for the participant/authorized representative and assisting party on the proper use of the AMD system at the time of installation and subsequently when needed. The training will include:

A) demonstration of the use, including any adaptations for operation, general care, and maintenance of the unit/equipment;

B) explanation of the AMD provider's services and notification processes;

C) instruction on any testing or monitoring used to assure the proper functioning of the AMD unit/equipment, including how to report any malfunctions; and

D) providing the participant/authorized representative/assisting party with easy to understand written instructions in the use, general care and maintenance of the AMD unit/equipment. These instructions will be available in options such as non-English languages, large print, Braille, and audible recordings to meet the participant's needs.

4) ensuring the participant/authorized representative reviews their assisting party designation at least every six~~6~~ months. Any changes in this designation must be sent to the CCU within five~~5~~ calendar days after the date of execution of the assisting party change. If there is a change in designation, the AMD provider must complete new training as required under subsection (b)(3) within seven~~7~~ calendar days after the date of execution of the assisting party change.

5) both:

A) obtaining the signature of the participant/authorized representative to verify that:

i) the AMD unit/equipment was delivered and installed; and

ii) instructions and demonstration were given and understood by the participant/authorized representative; and.

B) providing to the CCU and the participant/authorized representative a copy of the verification, to be kept on file at the CCU.

6) maintaining adequate local staffing levels of qualified personnel to conduct and provide necessary administrative activities, installation, in-home training, unit/equipment monitoring, technical support, AMD unit programming, and repair requests in a timely manner. An AMD provider must have a written training program for personnel and be able to demonstrate that its staff members are qualified and have passed background checks.

7) repairing or replacing the AMD unit/equipment within 24 hours after receiving a malfunction report. This timeline will be extended if requested by the participant/authorized representative/assisting party.

8) alerts to the participant/authorized representative and assisting party when electric power to the AMD unit has been interrupted (e.g., unplugged) and the unit is operating on a standby power source.

9) notification to the CCU within one calendar~~1 business~~ day after installation of the AMD unit and working with the appropriate care coordinator to resolve service complaints from the participant/authorized representative/assisting party.

10) notification to the CCU within two~~2~~ calendar days if the AMD service cannot be initiated or must be terminated.

11) maintaining records in accordance with Section 240.1544 relating to participant referral and service statistics, including unit/equipment delivery; unit installation and programming; participant/authorized representative and assisting party training; missed medication notifications and dispositions; other AMD unit/equipment monitoring and test

1375 transmission activity; unit/equipment malfunction, repair and replacement;
1376 power interruption alerts; notifications to the CCUs; billing and payment
1377 information; and personnel qualifications, training and background
1378 checks.
1379
1380 12) making available participant reports on missed medication doses, power
1381 and battery status, and other reporting features on an ongoing basis to the
1382 participant/authorized representative, assisting party and care coordinators
1383 via a privacy-protected and secure website or other modality.
1384
1385 13) providing access to individual and aggregate reports and AMD system
1386 performance measures on an ongoing basis to authorized persons through
1387 a privacy-protected and secure website or other modality.
1388
1389 14) providing ad hoc reports to the Department upon request.
1390
1391 c) Units of Service
1392
1393 1) One unit of installation service is the one-time fee to the AMD provider
1394 for the activity associated with the installation of the AMD unit/equipment
1395 in the participant's residence and training of the participant/authorized
1396 representative and assisting party.
1397
1398 2) One unit of monthly service is the fixed unit rate of reimbursement, per
1399 month, for the provider agency activity associated with providing the
1400 AMD service to each participant.
1401
1402 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
1403
1404 **Section 240.240 Information and Referral**
1405
1406 Information and Referral service is defined as assistance to participants to enable them to gain
1407 access to appropriate services and to receive services.
1408
1409 a) Service components of information and referral include:
1410
1411 1) A brief assessment of the participant's needs to facilitate appropriate
1412 referral to and follow-up with community resources;
1413
1414 2) Assisting participants in applying for benefits provided by federal, state
1415 and local agencies;
1416
1417 3) Follow-up to ensure that participant was linked to community-based

services and supports;

4) Information and referral may also encompass program-related public information efforts.

b) Unit of Service
One unit of Information and Referral service is one~~1~~ incoming telephone call received by the professional information and referral staff.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.260 Care Coordination Service

Care coordination service is defined as the provision of a comprehensive needs assessment and service coordination by CCUs to assist an older person to gain access to and receive needed services. The participant/authorized representative is provided the opportunity to lead the person-centered planning process.

a) Service Components
Specific components of care coordination service include the following:

1) Review of all inquiries to determine if a request for CCP services is desired, and maintenance of a referral request log.

2) Distribution and assistance with completion of CCP applications for charitable, private, and public benefits provided by federal, State and local agencies, including assistance with the initial application and redetermination for Medicaid benefits.

3) Performance of determinations/redeterminations of eligibility, including a comprehensive needs assessment, the development of a person-centered plan of care and authorization/referral of CCP services.

4) Completion of a minimum of one~~1~~ face-to-face contact with the participant in between initial assessment and annual reassessment. The face-to-face visit is to occur between four~~4~~ and eight~~8~~ months after the last determination or redetermination of eligibility.

5) Reporting of critical events includes critical incidents, service improvement program complaints, and requests for change of status in the Department's automated reporting system. Completing initial critical event reports will occur within seven~~7~~ days after the date the event occurred or was identified to have occurred. All critical event reports will be closed to

reflect mandatory follow-up with CCP participants within 60 days after the date the event occurred or was identified to have occurred. Critical event report closure will occur through completion of the 60-day review summary housed in the Department's automated reporting system.

6) Availability to receive inquiries and requests for services and supports, by telephone or in person, and respond to those inquiries and requests.

7) Choices for Care prescreenings and postscreenings (see Section 240.1010).

8) Department of Healthcare and Family Services (HFS) ~~OBRA-1 (~~Level I ~~ID~~ Screen~~)~~.

9) Provide referrals to other needed services.

10) Implementation of services and participant transfers.

11) Authorization of all actions related to the disposition of CCP services as required by this Part.

b) Comprehensive Assessments

1) A comprehensive assessment is required when a participant needs services to remain living independently in the community or is at imminent risk of nursing facility placement.

2) A comprehensive assessment is not warranted when a participant only requires a referral to services (e.g., providing contact information for a vendor).

3) Conditions triggering a comprehensive assessment may include, but are not limited to:

A) multiple or complex health problems which are often chronic in nature, and may affect the ability of the participant to live independently, such as musculoskeletal disorders, strokes, heart disorders, or mental health issues (e.g., Alzheimer's disease, major depression, or organic brain syndrome);~~.~~

B) lack of sufficient formal or informal supports; or

C) sudden and permanent loss of a primary caregiver.

1504
1505 4) The Care Coordinator will appropriately complete the comprehensive
1506 assessment tool authorized by the Department, or any successor
1507 assessment tool, used to determine need for community-based or long-
1508 term services and supports, that is relevant to the participant in a manner
1509 consistent with the responsibilities set forth under Section 240.1420.
1510
1511 c) Goals of Care
1512
1513 1) Each participant/authorized representative is provided the opportunity to
1514 lead the person-centered planning process where possible. The
1515 participant's authorized representative should have a participatory role, as
1516 needed and defined by the participant, unless State law confers decision-
1517 making authority to the legal representative.
1518
1519 2) If a participant's Goals of Care cannot be developed to create an adequate
1520 person-centered plan of care, the Care Coordinator is required to discuss
1521 the risks associated with the preferences and selections made regarding
1522 one or more specific goals by the participant/authorized representative and
1523 suggest any alternative options and/or referrals that might be available to
1524 mitigate risk.
1525
1526 3) Each participant will be advised by the Care Coordinator of their~~his/her~~
1527 right to accept or refuse some or all offered services developed in
1528 participants' Goals of Care.
1529
1530 d) Reassessments
1531
1532 1) A reassessment will be conducted face-to-face on at least an annual basis
1533 to determine if the participant remains eligible for the program or if
1534 changes in the participant's services under the person-centered plan of care
1535 are needed and/or the Goals of Care need to be revised.
1536
1537 2) A reassessment will also be conducted when requested by a
1538 participant/authorized representative or when a participant may have
1539 experienced a change in their~~his/her~~ needs.
1540
1541 3) The participant/authorized representative develops their~~his/her~~ own
1542 revised Goals of Care with input from the Care Coordinator consistent
1543 with the responsibilities set forth in Section 240.1420.
1544
1545 e) Unit of Service
1546 Several different types of assessments constitute a care coordination unit of

service for which reimbursement is made.

1) Completion of one~~1~~ initial eligibility determination for CCP services constitutes one~~1~~ unit.

2) Completion of one~~1~~ required continuous eligibility redetermination of CCP eligibility constitutes one~~1~~ unit. A redetermination shall be completed at least annually.

3) Completion of either one~~1~~ face-to-face prescreening or postscreen of a participant constitutes one~~1~~ unit.

4) Completion of one~~1~~ HFS Interagency Certification of Screening Results form constitutes one~~1~~ unit.

5) Availability to receive participant inquiries and requests, by telephone or in person, and to respond to those inquiries and requests for each active participant per month constitutes one~~1~~ unit.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.270 Alternative Provider

a) An alternative provider is defined as an individual~~ or an agency~~ selected by the participant, assisted by the CCU and authorized by the Department to provide CCP services to a participant only if the following criteria are met:

1) a contractual provider has failed to provide the services as required by the person-centered plan of care; and

2) there is no contractual provider available to provide the services as required by the person-centered plan of care.

b) The alternative provider must meet all the requirements for employment and be hired by the contractual provider.

c~~b~~) The contractual provider is required to supervise the alternative provider.~~Alternative providers may be supervised by the participant or agency providing the services, as required by the person-centered plan of care.~~ The service components and hours of service to be provided, as required by the person-centered plan of care, shall conform to the service components as defined in Section 240.210.

1590 ~~c) The appropriate CCU shall be responsible for monitoring of alternative provider~~
1591 ~~services.~~
1592
1593 d) An alternative provider shall be authorized by the Department prior to provision
1594 of services to the participant.
1595
1596 e) Unit of Service
1597
1598 ~~1)~~ One unit of alternative in-home service is one~~1~~ hour of direct service
1599 provided to the participant while in the participant's home, while providing
1600 transportation/escort to the participant to medical facilities, or while
1601 performing essential errands/shopping or conducting essential participant
1602 business with or on behalf of the participant.
1603
1604 ~~2) For services that the provider was unable to provide due to either the~~
1605 ~~participant's absence without prior provider notification or refusal to admit~~
1606 ~~the worker into the home to provide service (see Section 240.350), 1 unit~~
1607 ~~of documented in-home service per occurrence will be reimbursed to the~~
1608 ~~alternative in-home provider to a maximum of 2 units per participant per~~
1609 ~~State fiscal year.~~
1610
1611 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
1612
1613 SUBPART C: RIGHTS AND RESPONSIBILITIES
1614
1615 **Section 240.300 Participant Rights and Responsibilities**
1616
1617 The Department will administer CCP to assure certain rights to participants in accordance with
1618 the Home Care Participant Bill of Rights (see 20 ILCS 2405/17.1 and 320 ILCS 42/40) and the
1619 Medicaid Recipient Bill of Rights (see 305 ILCS 5/11-28). In addition, the Department will
1620 assure that participants receive an explanation of their rights and responsibilities. A copy of the
1621 rights and responsibilities shall be provided in written format to all participants during the initial
1622 visit for determination of eligibility and~~or~~ upon request by the participant.
1623
1624 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
1625
1626 **Section 240.320 Nondiscrimination**
1627
1628 a) No eligible participant with a disability or protected person under other federal
1629 and State civil rights laws who requests/receives services may be discriminated
1630 against under CCP.
1631

b) A participant/authorized representative may file a discrimination complaint with a provider~~vendor~~, a CCU, the Department, or other federal or State agency with jurisdiction over civil rights laws (see 4 Ill. Adm. Code 1725).

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.330 Freedom of Choice

a) A participant has the right to request and, if eligible, to receive available CCP services. A participant may choose at any time not to receive services for which eligibility has been determined.

b) A participant/authorized representative shall be informed of, and have the right to choose from, choices regarding available services, supports and providers~~vendors~~ in the participant's CCU service area:

1) at the time of initial determination of eligibility or subsequent redetermination of the participant;~~ or~~

2) at the time of determination of presumptive eligibility for interim services; ~~or~~

3) at any time the participant/authorized representative requests a change of providers~~/vendors~~; or

4) at the time of a Department-initiated total or partial caseload transfer.

c) The person-centered planning process includes a method for the participant/authorized representative to request updates to the person-centered plan of care.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.340 Confidentiality/Safeguarding of Case Information

a) For protection purposes, any information about a participant's case is confidential and may be used only for purposes directly related to the administration of the CCP. Information that is considered to be included in the administration of the program is as follows:

1) Establishing a participant's initial/continuing eligibility, preventing duplicate coverage under another Home and Community-Based Service (HCBS) Waiver, and providing assistance in transitioning to other

programs in appropriate instances.

2) Establishing the extent of a participant's: assets and income; determination of need under CCP; person-centered plan of care; case notes and other benefits. This includes recovery of payments and investigating allegations of fraud or other abuse of publicly funded benefits. This information may be shared in a secure manner by and among the Department and the Social Security Administration, the Department of Employment Security, HFS, the Department of Human Services, the Department of Revenue, the Secretary of State, the U.S. Department of Veterans Affairs, and any other governmental entity only to the extent that there is no conflict with any federal or State law or regulation.

3) Finding and linking needed services and resources available to an eligible participant, including information about new laws or changes in public benefit programs.

4) Assuring the health, safety, and welfare of the participant, submission of required critical events reports,~~including~~ reporting alleged or suspected abuse, neglect, financial exploitation, or self-neglect, assisting with investigations conducted under the Adult Protective Services Program, and making referrals to the State/Regional Long Term Care Ombudsman Programs.

5) Collecting data for the Department's demonstration/research projects.

6) Compliance with legal proceedings in response to valid court or administrative agency orders.

7) Directing and planning programming to transform long-term services and supports in Illinois and to maximize Federal Financial Participation in State expenditures under Medical Assistance Programs.

b) Use of information for commercial, personal, political or other purposes not specified in this Section is specifically prohibited. Information about a participant's case under the CCP is exempt from disclosure under the Freedom of Information Act [5 ILCS 140].

c) The Department, CCUs and vendors shall inform all agencies and governmental departments to whom information is furnished that this material is confidential and must be so considered by the agency or governmental department.

d) Any information received from other agencies or persons, which includes the

1718 express statement that the information is not to be released to the
1719 participant/authorized representative or to any other person or agency under any
1720 circumstances, is prohibited from release as case information. Requests for this
1721 information shall be referred to the originator of the restricted information.
1722
1723 e) If any information about a participant or document contained in the participant's
1724 case file is to be used for any purpose other than the administration of CCP, the
1725 CCU ~~or the vendor~~ shall obtain a Release of Information form signed by the
1726 participant /authorized representative. The Release of Information form shall be
1727 placed in the participant's case record.
1728
1729 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
1730
1731 **Section 240.350 Participant/Authorized Representative Cooperation**
1732
1733 Participants/authorized representatives shall cooperate with the representatives of the
1734 Department/CCUs/providers in determinations of eligibility, redeterminations, other necessary or
1735 required face-to-face visits, or provision of CCP services.
1736
1737 a) The~~Failure to cooperate in the~~ actions specified below shall be considered non-
1738 cooperative and may result in a MOU as set forth in Section 240.930 or
1739 termination from CCP services:~~and shall be cause for suspension.~~
1740
1741 1) Repeated absences that disrupt the provision of in-home services or ADS
1742 services without advising the provider. Such absences should result in a
1743 reassessment before pursuing a MOU;~~A participant/authorized~~
1744 ~~representative shall notify the office of the provider at least 1 day in~~
1745 ~~advance when the participant will not be present in his/her home to receive~~
1746 ~~scheduled services.~~
1747
1748 ~~A) If the participant's absence from his/her home on a day services are~~
1749 ~~scheduled is due to an emergency, the participant/authorized~~
1750 ~~representative shall advise the office of the provider as quickly as~~
1751 ~~possible and it will not be considered non-cooperative.~~
1752
1753 ~~B) The provider shall document the absences of the participant~~
1754 ~~without prior notification (except any absence caused by an~~
1755 ~~emergency) and shall be reimbursed by the Department for 2 such~~
1756 ~~absences (see Section 240.210).~~
1757
1758 ~~C) Two such documented absences within a State fiscal year shall be~~
1759 ~~cause for suspension of the participant's services pending~~
1760 ~~termination. The provider has the option of not reporting non-~~

~~cooperative absences; however, if the second non-cooperative absence is reported with request for reimbursement, suspension procedures shall be implemented.~~

~~D)~~ ~~The provider shall verbally advise the CCU on the same day, if possible, but not later than the next work day after the date of the second non-cooperative absence. A written report including, at a minimum, the names of the participant and the worker, and the dates of the first and second non-cooperative absence, shall be submitted by the provider to the CCU within 2 work days after the date of the second non-cooperative absence. The written report may be submitted in person or through mail, facsimile or electronic means.~~

~~E)~~ ~~Upon receipt of verbal notification of the second documented non-cooperative absence within a State fiscal year, the CCU shall suspend the participant's services as required in Section 240.930. The date of suspension shall be the date that the second non-cooperative absence occurred.~~

2) Refusing to allow the provider to enter the home to provide services;~~A participant/authorized representative shall notify the office of an adult day service provider at least 1 day in advance when the participant will not be attending the adult day service site or will not be in need of transportation to or from the adult day service site, as scheduled and required by the person-centered plan of care.~~

~~A)~~ ~~If the participant's absence from the adult day service site or refusal to accept transportation to the adult day service site is due to an emergency, the participant/authorized representative shall advise the office of the provider as quickly as possible and it will not be considered non-cooperative.~~

~~B)~~ ~~The provider shall document the participant's absence or refusal to accept transportation without prior notification thereof (except any absence caused by an emergency) and shall be reimbursed by the Department for 2 such absences or refusals (refer to Section 240.230).~~

~~C)~~ ~~Two such documented absences or refusals within a State fiscal year shall be cause for suspension of the participant's services pending termination. The provider has the option of not reporting non-cooperative absences; however, if the second non-cooperative~~

1804 ~~absence is reported with request for reimbursement, suspension~~
1805 ~~procedures shall be implemented.~~
1806
1807 ~~D)~~ ~~The provider shall verbally advise the CCU on the same day, if~~
1808 ~~possible, but not later than the next work day after the date of the~~
1809 ~~second non-cooperative absence or refusal. A written report~~
1810 ~~including, at a minimum, the names of the participant and the~~
1811 ~~worker and the dates of the first and second non-cooperative~~
1812 ~~absence or refusal, shall be mailed by the provider to the CCU~~
1813 ~~within 2 work days after the date of the second non-cooperative~~
1814 ~~absence or refusal. The written report may be submitted in person~~
1815 ~~or through mail, facsimile or electronic means.~~
1816
1817 ~~E)~~ ~~Upon receipt of verbal notification of the second documented non-~~
1818 ~~cooperative absence or refusal within a State fiscal year, the CCU~~
1819 ~~shall suspend the participant's adult day service (including~~
1820 ~~transportation if specified in the person-centered plan of care) as~~
1821 ~~required in Section 240.930. The date of suspension shall be the~~
1822 ~~date that the second non-cooperative absence or refusal occurred.~~
1823
1824 3) Interfering with any provision of the services specified in the person-
1825 centered plan of care;~~A participant/authorized representative shall not~~
1826 ~~refuse to allow the provider into the participant's home to provide services.~~
1827
1828 ~~A)~~ ~~The provider shall document the refusal to allow services to be~~
1829 ~~provided and shall be reimbursed by the Department for 2 such~~
1830 ~~refusals (see Section 240.210).~~
1831
1832 ~~B)~~ ~~Two such documented refusals within a State fiscal year shall be~~
1833 ~~cause for suspension of the participant's services pending~~
1834 ~~termination. The provider shall verbally advise the CCU on the~~
1835 ~~same day, if possible, but not later than the next work day after the~~
1836 ~~date of the second refusal. A written report including, at a~~
1837 ~~minimum, the names of the participant and the worker and the~~
1838 ~~dates of the first and second refusal, shall be mailed by the~~
1839 ~~provider to the CCU within 2 work days after the date of the~~
1840 ~~second refusal. The written report may be submitted in person or~~
1841 ~~through mail, facsimile or electronic means.~~
1842
1843 ~~C)~~ ~~Upon receipt of verbal notification of the second documented~~
1844 ~~refusal within a State fiscal year, the CCU shall suspend the~~
1845 ~~participant's services as required in Section 240.930. The date of~~
1846 ~~suspension shall be the date that the second refusal to allow service~~

~~occurred.~~

4) Residing outside the State for longer than 60 days while receiving EHRS services without an exemption from the CCU; or~~A participant/authorized representative shall not interfere with provision of the services specified in the person-centered plan of care, either in the participant's home or in any adult day service site.~~

~~A) The provider shall document the interference with provision of the services specified in the person-centered plan of care.~~

~~B) Two such documented instances of interference within a State fiscal year shall be cause for suspension of the participant's services pending termination. The provider shall verbally advise the CCU on the same day, if possible, but not later than the next work day after the date of the second occurrence. A written report including, at a minimum, the names of the participant and the worker and the dates of the first and second occurrence, shall be submitted by the provider to the CCU within 2 work days after the date of the second occurrence. The written report may be submitted in person or through mail, facsimile or electronic means.~~

~~C) Upon receipt of verbal notification of the second documented occurrence of interference within a State fiscal year, the CCU shall suspend the participant's services as required in Section 240.930. The date of suspension shall be the date of the second occurrence of interference occurrence.~~

5) Purposefully damaging or losing AMD equipment or EHRS base unit or activation devices without a law enforcement report of theft or intentional damage.~~A participant /authorized representative or any family member/friend/acquaintance of the participant/authorized representative shall not threaten or act abusively (e.g., physical, verbal, sexual) or display a weapon (e.g., gun, knife) against any representative of the Department, CCU or provider who is present in the participant's home or at an adult day service site. The participant/authorized representative shall be responsible for any animal present in the home of the participant and shall prevent the animal from physically harming a representative of the Department/CCU/provider.~~

~~A) If the threat or abuse takes place in a participant's home, the party who has been threatened or abused shall leave the premises immediately and verbally advise the CCU on the same day, if~~

1890 possible, but not later than the next work day.
1891
1892 B) If the threat or abuse takes place in an adult day service site, the
1893 family/authorized representative shall be advised immediately and
1894 the CCU shall verbally be advised on the same day, if possible, but
1895 not later than the next work day.
1896
1897 C) A written report including, at a minimum, the name of the
1898 participant and the in-home worker/adult day service site worker,
1899 and the date and details of the threat or abuse, shall be submitted
1900 by the provider to the CCU within 2 work days after the date that
1901 the threat or abuse occurred. The written report may be submitted
1902 in person or through mail, facsimile or electronic means.
1903
1904 D) Upon receipt of verbal notification of threat or abuse, the CCU
1905 shall, on the same day, if possible, but not later than the next work
1906 day:
1907
1908 i) suspend a participant's services in the participant's home
1909 and/or at an adult day service site, as required in Section
1910 240.930; or
1911
1912 ii) suspend a participant's determination of eligibility process
1913 as required in Section 240.930.
1914
1915 E) The date of suspension shall be the date that the threat or abuse
1916 occurred.
1917
1918 6) A participant/authorized representative and/or any family
1919 member/friend/acquaintance of the participant/authorized representative
1920 will be responsible for damages to or loss of the AMD equipment or
1921 Emergency Home Response base unit or activation devices unless a law
1922 enforcement report of theft or intentional damage has been filed.
1923
1924 A) The provider will document the damages/loss of the equipment.
1925
1926 B) One documented occurrence of intentional damages/loss of
1927 equipment will be cause for suspension of the participant's
1928 services, pending termination. The provider shall verbally advise
1929 the CCU on the same day, if possible, but not later than the next
1930 work day after the date of the occurrence. A written report,
1931 including, at a minimum, the names of the participant and the
1932 worker and the date of the occurrence, will be submitted by the

1933 ~~provider to the CCU within 2 work days after the date of the~~
1934 ~~occurrence. The written report may be submitted in person or~~
1935 ~~through mail, facsimile or electronic means.~~
1936
1937 ~~C) Upon receipt of verbal notification of the documented occurrence~~
1938 ~~of intentional damages or loss of equipment within a State fiscal~~
1939 ~~year, the CCU will suspend the participant's services as required in~~
1940 ~~Section 240.930. The date of suspension will be the date of the~~
1941 ~~occurrence of damages to or loss of equipment.~~
1942
1943 ~~7) The CCU shall notify the participant/authorized representative and the~~
1944 ~~provider of the suspension in accordance with Section 240.930(c) and (d).~~
1945
1946 ~~8) The CCU shall develop a memorandum of understanding between the~~
1947 ~~participant/authorized representative of the CCU and the provider, in~~
1948 ~~accordance with Section 240.930(e).~~
1949
1950 ~~9) Upon the execution of the memorandum of understanding, the~~
1951 ~~participant's services or the participant's determination of eligibility~~
1952 ~~process, as appropriate, shall be reinstated in accordance with Section~~
1953 ~~240.930(f).~~
1954
1955 ~~10) Failure to sign a memorandum of understanding shall be grounds for~~
1956 ~~termination or denial, as appropriate.~~
1957
1958 ~~11) If, following reinstatement, the requirements of the memorandum of~~
1959 ~~understanding have not been adhered to by the participant/authorized~~
1960 ~~representative, the request for services shall be denied or services shall be~~
1961 ~~terminated, as appropriate.~~
1962
1963 ~~12) Notification of denial or termination shall be in accordance with Section~~
1964 ~~240.910 or 240.945, as appropriate.~~
1965
1966 b) The provider must document each time the participant is non-cooperative. If the
1967 action is due to an emergency, then it will not be considered non-
1968 cooperative.~~Failure to cooperate in the actions specified in this subsection (b)~~
1969 ~~shall be considered non-cooperation and shall be cause for denial of a request for~~
1970 ~~services or termination of service, as appropriate.~~
1971
1972 ~~1) A participant/authorized representative or any family~~
1973 ~~member/friend/acquaintance of the participant/authorized representative~~
1974 ~~shall not inflict physical injury upon any representative of the Department,~~
1975 ~~CCU or provider, either in the participant's home or while the participant~~

1976 ~~is attending an adult day service site.~~
1977
1978 ~~A) If the infliction of physical injury takes place in the participant's~~
1979 ~~home, the injured party shall leave the premises immediately and~~
1980 ~~verbally advise the CCU on the same day, if possible, but not later~~
1981 ~~than the next work day.~~
1982
1983 ~~B) If the infliction of physical injury takes place in an adult day~~
1984 ~~service site, the family/authorized representative shall be advised~~
1985 ~~immediately and the participant shall be removed immediately.~~
1986 ~~The CCU shall verbally be advised on the same day, if possible,~~
1987 ~~but not later than the next work day.~~
1988
1989 ~~C) A written report including, at a minimum, the names of the~~
1990 ~~participant and the worker/adult day service site worker, and the~~
1991 ~~date and details of the infliction of physical injury, shall be mailed~~
1992 ~~by the provider to the CCU within 2 work days after the date that~~
1993 ~~the physical injury was inflicted. The written report may be~~
1994 ~~submitted in person or through mail, facsimile or electronic means.~~
1995
1996 ~~D) Upon receipt of verbal notification of physical injury the CCU~~
1997 ~~shall, on the same day, if possible, but not later than the next work~~
1998 ~~day:~~
1999
2000 ~~i) institute immediate denial of a request for services or~~
2001 ~~termination of services. The effective date of denial or~~
2002 ~~termination shall be the date that the infliction of physical~~
2003 ~~injury occurred;~~
2004
2005 ~~ii) verbally notify the participant/authorized representative of~~
2006 ~~the denial or termination. Written notification shall be sent~~
2007 ~~by certified mail to the participant/authorized~~
2008 ~~representative, and by regular mail to the provider within 5~~
2009 ~~calendar days after the date of the verbal notification; and~~
2010
2011 ~~iii) verbally notify the Department of the denial or termination~~
2012 ~~followed by a written report within 5 calendar days after~~
2013 ~~the date of the verbal notification.~~
2014
2015 ~~2) Participants/authorized representatives shall provide assistance in securing~~
2016 ~~documentation and/or factual information to be utilized in the~~
2017 ~~determination of initial and continuing eligibility for CCP services, as well~~
2018 ~~as the type, level and amount of services to be provided. Refusal to~~

~~provide the specified assistance needed shall be cause for denial of a request for service or termination of a participant's services as appropriate.~~

~~3) Participants/authorized representatives shall provide a mailing address, including sufficient information to enable the Department/CCU/provider to locate the participant/authorized representative (i.e., the name, address and telephone number of a contact through whom the participant may be located; it may be necessary to provide directions to the participant's home). Refusal to provide the specified assistance needed shall be cause for denial of a request for service or termination of a participant's services as appropriate.~~

~~4) Notification of denial or termination shall be in accordance with Section 240.910 or 240.945, except as specified in subsection (b)(1)(D).~~

c) The provider shall verbally notify the CCU on the same day, if possible, but no later than the next work day, that the participant was non-cooperative. Within two working days after the verbal notification, the provider shall submit to the CCU a written report including, at a minimum, the names of the participant and the worker, the dates a brief description of the incident.

d) The actions specified in this subsection (d) shall be considered non-cooperation and shall be cause for denial of a request for services or termination of service, as appropriate.

1) Refusal to sign a MOU

2) Failure to adhere to the terms of a MOU

3) Refusal to provide the necessary documentation needed to determine initial and continuing eligibility for CCP services

4) Refusal to provide a mailing address and/or an email address, including sufficient information to enable the Department/CCU/provider to locate the participant/authorized representative (i.e., the name, address and telephone number of a contact through whom the participant may be located; it may be necessary to provide directions to the participant's home).

e) Each action specified in subsection (d) shall be documented by the provider and the documentation submitted to the CCU within two work days. The written report must include the names of the participant and/or the worker, the dates the action occurred, and a brief description of the action.

2062
2063 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
2064
2065 **Section 240.355 Violence By Participants/Authorized Representatives**
2066
2067 a) A participant/authorized representative or any family member, friend, or
2068 acquaintance of the participant/authorized representative shall not threaten or act
2069 abusively (e.g., physical, verbal, sexual) or display a weapon (e.g., gun, knife)
2070 against any representative of the Department/CCU/provider who is present in the
2071 participant's home or anyone at an ADS site. The participant/authorized
2072 representative shall be responsible for any animal present in the home of the
2073 participant and shall prevent the animal from physically harming a representative
2074 of the Department/CCU/provider.
2075
2076 1) If the threat or abuse takes place in a participant's home, the party who has
2077 been threatened or abused shall leave the premises immediately and
2078 verbally advise the CCU on the same day, if possible, but not later than the
2079 next work day.
2080
2081 2) If the threat or abuse takes place in an ADS site, the family/authorized
2082 representative shall be advised immediately and the CCU shall verbally be
2083 advised on the same day, if possible, but not later than the next work day.
2084
2085 3) The provider shall submit to the CCU a written report including, at a
2086 minimum, the name of the participant and the in-home worker/ADS site
2087 worker, and the date and details of the threat or abuse, within two work
2088 days after the date that the threat or abuse occurred.
2089
2090 4) Upon receipt of verbal notification of threat or abuse, the CCU shall, on
2091 the same day, if possible, but not later than the next work day:
2092
2093 A) suspend a participant's services in the participant's home and/or at
2094 an ADS site pending the issuance of a MOU, and
2095
2096 B) suspend a participant's determination of eligibility process pending
2097 the issuance of a MOU.
2098
2099 5) The CCU must inform the participant/authorized representative of the
2100 suspension within one calendar day of the suspension. The date of
2101 suspension shall be the date that the participant/authorized representative
2102 is notified.
2103

2104 6) The CCU shall have five calendar days from the date of suspension to
2105 execute a MOU with the participant.
2106
2107 b) A participant/authorized representative or any family member/friend/acquaintance
2108 of the participant/authorized representative shall not inflict physical injury upon
2109 any representative of the Department/CCU/provider, either in the participant's
2110 home or while the participant is attending an ADS site.
2111
2112 1) If the infliction of physical injury takes place in the participant's home, the
2113 injured party shall leave the premises immediately and verbally advise the
2114 CCU on the same day, if possible, but not later than the next work day.
2115
2116 2) If the infliction of physical injury takes place in an ADS site, the
2117 family/authorized representative shall be advised immediately, and the
2118 participant shall be removed immediately. The CCU shall verbally be
2119 advised on the same day, if possible, but not later than the next work day.
2120
2121 3) The provider shall submit to the CCU a written report including, at a
2122 minimum, the names of the participant and the worker/ADS site worker,
2123 and the date and details of the infliction of physical injury, within two
2124 work days after the date that the physical injury was inflicted.
2125
2126 4) Upon receipt of verbal notification of physical injury, the CCU shall, on
2127 the same day, if possible, but not later than the next work day:
2128
2129 A) institute immediate denial of a request for services or termination
2130 of services. The effective date of denial or termination shall be the
2131 date that the infliction of physical injury occurred;
2132
2133 B) verbally notify the participant/authorized representative of the
2134 denial or termination. Written notification shall be mailed or
2135 emailed to the provider within five calendar days after the date of
2136 the verbal notification; and
2137
2138 C) verbally notify the Department of the denial or termination
2139 followed by a written report within five calendar days after the
2140 date of the verbal notification.
2141
2142 (Source: Added at 48 Ill. Reg. ______, effective ____________)
2143
2144 SUBPART D: APPEALS
2145
2146 **Section 240.400 Appeals and Fair Hearings**

a) Any participant who requests or receives CCP services of~~ any kind~~ has the right to appeal a decision or~~,~~ action~~ or inaction~~ of the Department/CCU/Provider~~Department, a CCU or a provider~~. If the decision, action or inaction is based on automatic, non-discretionary changes in eligibility, rates or benefits required by federal or State statute or regulation, that adversely affect some or all participants, the appeal will be automatically denied, and the participant will not be afforded a hearing.

b) The participant/authorized representative shall be informed in writing by the CCU of their~~his/her~~ right to appeal at the initial home visit, at the time the action is taken and upon request.~~time the participant/authorized representative is notified of the action taken. The participant shall be given an explanation of the right to appeal at the time of the initial home visit at which the action is taken and upon request. A copy of the rights and responsibilities of participants who request services under CCP and an explanation of the right to appeal shall be provided in written format during the initial home visit for determination of eligibility and upon request.~~

c~~b~~) A~~It shall be the responsibility of each~~ participant/authorized representative may file an appeal with the Department by completing and submitting a Notice of Appeal form.~~to advise the Department of his/her intent to appeal.~~

~~c) The effective date of the appeal is the date a participant/authorized representative indicates to the Department the intent to appeal either by telephone or in writing.~~

d) If the Department is advised of the intent to appeal either by letter or by telephone, the Department shall, within two business~~2 work~~ days, send to the appellant a Notice of Appeal form.~~to Department on Aging form to be completed and signed by the appellant/authorized representative.~~

~~e) The written notice of appeal must be filed with the Department on a Notice of Appeal to Department on Aging form and shall be completed and executed by the appellant/authorized representative and returned to the Department.~~

~~f) The executed Notice of Appeal to Department on Aging form must be submitted to the Department at its main office in Springfield.~~

~~g) No later than 10 work days after the date of receipt of Notice of Appeal to Department on Aging form, the Department shall send written acknowledgment of receipt to the appellant/authorized representative and to all other parties to the appeal.~~

~~h) The written Notice of Appeal to Department on Aging shall include the following:~~

~~1) the name, address and telephone number of the participant filing the appeal, or on whose behalf the appeal is filed; and~~

~~2) the name, address and telephone number of the authorized representative, if any, filing the appeal on behalf of the participant;~~

~~3) the specific action being appealed, including the date of notice advising the participant/authorized representative of the action appealed and the effective date of that action; and~~

~~4) the name of the CCU, as indicated on the notice of the action being appealed.~~

<u>e</u>~~i~~) CCUs are to provide a copy of any notice of adverse action to any participant's authorized representative, if the participant has earned <u>ten</u>~~10~~ points on the Mini-Mental State Examination (MMSE). A single notice to a residence will suffice if the authorized representative is a family member living with the appellant.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.405 Representation

~~a)~~ The appellant may represent him/herself and/or may authorize legal counsel, a relative, a friend or other spokesperson to represent him/her.

~~b) Written authorization is not required unless the appellant is not present at the hearing and:~~

~~1) the representative is an employee, agent or representative of a hospital; or~~

~~2) the representative is an employee, agent or representative of a group care facility; or~~

~~3) the representative is a provider of Community Care services or an employee of an Area Agency on Aging; or~~

~~4) the Hearing Officer, in his/her judgment, has reason to question the representative's authority to serve as a representative.~~

~~c) A legal guardian or other appointed representative may represent a participant as authorized by a court of law. The Department may request identification and~~

~~other verification; however, a statement signed by the participant is not required.~~

~~d) Any action or inaction by the appellant's representative is considered action or inaction by the appellant.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.410 When the Appeal May Be Filed

a) The request for an~~right to~~ appeal must be on a Notice of Appeal form and must be filed~~exercised~~ within 60 calendar days after the date the notice of the action being appealed was sent to the participant.~~ advising the action being taken by the CCU, such as:~~

~~1) the date the notice was sent by a CCU of a decision on a request for a determination of eligibility for CCP services;~~

~~2) the date the notice was sent by a CCU or the Department of a reduction or termination of CCP services, except for instances involving automatic, non-discretionary changes in eligibility, rates or benefits required by federal or State statute or regulation; or~~

~~3) the date the notice was sent by a CCU or the Department of denial of a request or other action that aggrieves the participant, when that denial or action was other than an eligibility determination or a decision to reduce or terminate services.~~

b) If a Notice~~notice~~ of Appeal form~~appeal~~ is filed after the 60 calendar day time period, the appeal will be automatically denied.~~right to appeal is not affected. However, the final administrative decision of the Department will not be favorable to the appellant if it is determined that the 60 calendar day time period applies to the situation and has expired.~~

~~c) The 60 calendar day time limitation does not apply when:~~

~~1) a CCU or the Department fails to send the required written notification of the action taken that is being appealed;~~

~~2) a CCU or the Department fails to allow 15 calendar days from the date of the notice to the effective date of the action appealed;~~

~~3) a CCU, provider or the Department fails to take any action on a specific request made by a participant within 15 calendar days after the date of~~

~~request as required in Section 240.1520;~~

~~4) a CCU, provider or the Department denies a request without informing the participant in writing within 15 calendar days after the date of request, as required in Section 240.1520;~~

~~5) a CCU or provider failed to advise the participant/authorized representative of the right to appeal; or~~

~~6) a CCU or provider has violated CCP rules.~~

~~d) If a participant/authorized representative advised the Department by telephone of his/her intent to appeal and subsequently files a written appeal with the Department, the date of the documented telephoned intent shall be the date of filing of the appeal.~~

c~~e~~) ~~If the intent to appeal by or on behalf of a participant is filed within 10 calendar days after the date of the notice of adverse action (see to Section 240.160) and is followed by a written appeal as requested by the Department,~~ CCP services shall be continued at the level in effect prior to the notice of adverse action until the final decision in the appeal is reached, except for instances involving automatic, non-discretionary changes in eligibility, rates or benefits required by federal or State statute or regulation. In addition, if~~The participant/authorized representative and all other interested parties to the appeal shall be notified in writing by the Department of the continuation of the participant's services at the previous level. If~~ the Department determines that the health, safety or welfare of the provider/direct service worker will be jeopardized if service is continued (see Section 240.355~~240.350~~), the participant's right to continued service may be denied until the appeal decision is reached.

d~~f~~) Services shall not be continued during the appeal process for a participant receiving interim services. Those participants receiving interim services have not received full eligibility for the CCP and are only presumed eligible until a full determination of eligibility has been completed.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.415 What May be Appealed

The following actions of CCUs~~, providers~~ or the Department may be appealed:

~~a) Refusal to accept a referral for CCP services.~~

~~b) Failure to act upon a referral form within the mandated time period, unless delayed in any manner by the participant/authorized representative in the determination of eligibility process.~~

c) A decision to deny, reduce, terminate, or in any way change CCP services or how those services are provided. If the decision to reduce, terminate or in any way change CCP services is based on automatic, non-discretionary changes in eligibility, rates or benefits required by federal or State statute or regulation, which adversely affects some or all participants, the appeal will be automatically denied, and the participant affected will not be afforded a hearing.

~~d) Failure to advise prescreened participants/authorized representatives that they have a choice of:~~

~~1) nursing facility care, if eligible;~~

~~2) supported living program provider care, if eligible;~~

~~3) receiving in-home or community-based services, if eligible; or~~

~~4) declining any of these options.~~

~~e) A decision to reduce, terminate or in any way change CCP services or how those services are provided. If the decision to reduce, terminate or in any way change CCP services is based on automatic, non-discretionary changes in eligibility, rates or benefits required by federal or State statute or regulation, which adversely affects some or all participants, the appeal will be automatically denied and the participant affected will not be afforded a hearing.~~

d~~f~~) A decision to deny a request for redetermination.

e~~g~~) Failure to make a decision or take appropriate action on any reasonable request made by a participant within 15 calendar days after the date of the request.

f~~h~~) A decision to place a participant on a MOU.~~by a CCU to uphold a provider decision with which the participant/authorized representative does not agree.~~

g~~i~~) A decision to renew a MOU.~~Failure to advise the participant/authorized representative of his/her right to choose a Department authorized provider in the service area of the participant to provide the services required by the person-centered plan of care.~~

h~~j~~) The outcome of the determination of the eligibility for nursing facility level of

2362 care or the supportive living program setting.Failure of a CCU to advise a
2363 participant/authorized representative of any of his/her rights under CCP.
2364
2365 k) Failure of a CCU or provider to comply with CCP rules in this Part and 89 Ill.
2366 Adm. Code 220.
2367
2368 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
2369
2370 **Section 240.420 Consolidation ofGroup Appeals**
2371
2372 The Department may consolidate a number of participant appeals for the purpose of conducting a
2373 single group informal review and subsequent hearing if it determined. The consolidation must be
2374 based upon the Department's determination that all of the appeals involve the same complaint,
2375 and the only issue in question is one of State or federal law or policy. Consideration shall be
2376 given to the geographic proximity and the physical condition of the appellants. Each appellant
2377 has the option of withdrawing from the group and presenting their appeal individually.
2378
2379 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
2380
2381 **Section 240.425 Informal Review**
2382
2383 a) TheWhen an appeal is received by the Department, the Department will review
2384 each Notice of Appeal form and make a recommendation to the Director.shall
2385 proceed to conduct an informal review of the action or inaction serving as the
2386 basis of the appeal.
2387
2388 ba) The Department may contact the appellant/authorized representative to discuss
2389 the appeal request and/or request additional information.purpose of an informal
2390 review shall be to determine the facts in the appealed action or inaction.
2391
2392 cb) The recommendation will be submitted to the Director within 60 calendar days
2393 after the receipt of the Notice of Appeal form or receipt of the additional
2394 information, whichever is later.If the basis for the appeal involves the functioning
2395 of the participant in his/her environment or if the Department is unable to arrive at
2396 a decision based upon the facts presented, the Department or it's designated agent
2397 may conduct a face-to-face review in the participant's home.
2398
2399 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
2400
2401 **Section 240.430 Informal Review Findings**
2402
2403 a) Based on the recommendation, the Director may: Within 60 calendar days after
2404 the date of receipt of the Notice of Appeal to Department on Aging form, the

2405 ~~Department shall conduct an informal review and issue an Appeal Findings~~
2406 ~~Notice that may be delayed pending an extension of time caused by the appellant.~~
2407
2408 1) Dismiss the appeal based on any of the factors listed in Section 240.436
2409 and the appellant/authorized representative may request reconsideration
2410 within 15 days consistent with Section 240.436;
2411
2412 2) Uphold the appeal and the appeal file shall be closed;
2413
2414 3) Modify the original action and the appellant/authorized representative may
2415 request a hearing within 15 calendar days; or
2416
2417 4) Deny the appeal and the appellant/authorized representative may request a
2418 hearing withing 15 calendar days.
2419
2420 b) The Director's decision shall be in writing and sent by mail or email to the
2421 appellant/authorized representative.~~Appeal Findings Notice shall clearly state the~~
2422 ~~facts determined and decision of the Department based upon the informal review.~~
2423 ~~Copies shall be sent to all parties to the appeal.~~
2424
2425 ~~1) If the appeal is upheld, based upon the Department decision resulting from~~
2426 ~~the informal review, the appeal file shall be closed.~~
2427
2428 ~~2) If the original action is modified, based upon the Department decision~~
2429 ~~resulting from the informal review, the appeal shall automatically proceed~~
2430 ~~to hearing unless the appellant/authorized representative withdraws the~~
2431 ~~hearing request in writing.~~
2432
2433 ~~3) If the appeal is denied, based upon the Department decision resulting from~~
2434 ~~the informal review, the appeal shall automatically proceed to hearing~~
2435 ~~unless the appellant/authorized representative withdraws the hearing~~
2436 ~~request in writing.~~
2437
2438 c) The appellant/authorized representative may request a hearing by contacting the
2439 Department.~~CCUs are to provide a copy of any notice of adverse action to a~~
2440 ~~participant's authorized representative, if the participant has earned 10 points on~~
2441 ~~the Mini-Mental State Examination (MMSE). If the authorized representative is a~~
2442 ~~family member residing with the participant, the single notice to the participant~~
2443 ~~will suffice.~~
2444
2445 d) If a hearing is not requested, the Director's decision is a final administrative
2446 decision. The Department will make any planned change in services, which had
2447 been delayed pending the outcome of the appeal, immediately and will notify all

parties to the appeal in writing.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.435 Withdrawing an Appeal

~~a)~~The appellant/authorized representative, may withdraw the appeal at any time prior to or during the appeal process. The withdrawal must~~may~~ be submitted in writing and upon receipt, the Department will close the file.~~or by telephone.~~

~~b) The Department shall acknowledge the withdrawal of appeal and advise the appellant/authorized representative that the appeal is formally closed, in writing, by certified mail, return receipt requested.~~

~~c) The Department shall furnish copies of the acknowledgment of withdrawal to all interested parties to the appeal.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.436 Dismissing~~Cancelling~~ an Appeal

a) The Department may dismiss~~cancel~~ an appeal at any time during the appeal process for any of the following:

1) Appellant's death;

2) Appellant never received a notice of adverse action from the Department;

3) Appellant is not a CCP participant;

4) Appellant moves out of State;

5) Appellant's appeal is upheld by the Department;

6) The Department does not have jurisdiction;~~Appellant/ authorized representative does not submit a Notice of Appeal to the Department within 60 calendar days after the date the notice of adverse action was sent;~~

7) Appeal is not related to any CCP services; and/or

8) Appeal is filed by an unauthorized representative.

b) The Department shall advise the appellant/authorized representative that the appeal is dismissed by mail or email and shall include the reason for the appeal was dismissed and the right to request reconsideration.~~cancelled and formally closed, in writing, by certified mail, return receipt requested.~~

c) If the appellant/authorized representative does not agree with the reason for dismissal~~cancellation~~, the appellant/authorized representative may request reconsideration of the dismissal. The request must be~~must notify the Department,~~ in writing and submitted~~,~~ within ten calendar~~10 work~~ days after receipt of the dismissal~~Notice of Cancellation~~. The request should include any documentation that disproves the Department's finding.

d) The Department shall review the request for reconsideration and determine if the appeal should be reinstated.~~If the appellant/authorized representative notifies the Department, in writing, within 10 work days after receipt of the Notice of Cancellation, the~~ Department may~~shall~~ reinstate the appeal and continue the appeal process.

e) The Department shall furnish copies of the dismissal~~Notice of Cancellation~~ to all interested parties to the appeal.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.440 Exchanging~~Examining Department~~ Records and Pre-hearing Conferences

The~~Before or during the appeal hearing, if requested, the~~ Department and~~shall permit~~ the appellant/~~appellant's~~ authorized representative will provide copies of relevant documents, a list of potential witness, and a summary of potential testimony to be used at the hearing, to the other party. The Hearing Officer may schedule one or more pre-hearing conferences.~~to examine all portions of the case record and any other documents to be used at the hearing. Department records may be examined only in the presence of a Department employee. Copies of case material shall be provided by the Department upon request of the appellant/appellant's authorized representative. A charge of ten (10) cents per sheet shall be made for each copy provided.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.445 Hearing Officer

All hearings will be conducted by an impartial Hearing Officer authorized by the Director~~ of the Department~~ to conduct the hearing.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.450 The Hearing

The hearing will be conducted in accordance with Article 10 of the Illinois Administrative Procedure Act [5 ILCS 100/10] unless otherwise specified in this Part. The appellant has the burden of proof. ~~informal but *the rules of evidence and privilege as applied in civil cases in the circuit courts of this State shall be followed. Evidence not admissible under those rules of evidence may be admitted, however, (except where precluded by statute) if it is of a type commonly relied upon by reasonably prudent men in the conduct of their affairs.* (Illinois Administrative Procedure Act [5 ILCS 100/10-10 through 10-40]) The proceedings will be recorded. The appellant may present the case or have an authorized representative present it, and may bring witnesses to the hearing. The appellant/authorized representative shall have the opportunity before and during the hearing to examine material the Department plans to have available, which must include:~~

~~a) Statement of Facts; and~~

~~b) Pertinent case information, including all documents to be used at the hearing.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.451 Conduct of Hearing

The hearing may be conducted in person or with some or all parties, including the Hearing Officer~~hearing officer~~, present at different locations connected with each other by telephone, videoconference, or other electronic means. The proceedings will be recorded.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.455 Continuance of the Hearing (Repealed)

~~a) During the hearing, the appellant/authorized representative may request a continuance from the Hearing Officer. The continuance shall be granted if:~~

~~1) the appellant needs additional information;~~

~~2) a necessary witness is absent;~~

~~3) the appellant is ill;~~

~~4) the appellant's authorized representative is unavailable; or~~

~~5) for any other reason that necessitates a continuance in order for the appellant to present the appeal.~~

~~b) The appeal shall be continued to the next available docket opening, if acceptable to the appellant.~~

~~c) If the continuance is allowed, the ninety (90) calendar day time limitation of the appeal process shall be extended by the number of calendar days of the allowed continuance.~~

(Source: Repealed at 48 Ill. Reg. ______, effective ____________)

Section 240.460 Continuance or Postponement of the Hearing

~~a) A hearing shall be postponed for a reasonable period if:~~

~~1) the appellant needs additional information;~~

~~2) a necessary witness is absent;~~

~~3) the appellant is ill;~~

~~4) the appellant's authorized representative is unavailable; or~~

~~5) for any other reason that necessitates a postponement in order for the appellant to present the appeal.~~

a~~b~~) The appellant/authorized representative or the Department Representative may request a continuance or postponement, which shall be in writing to the Hearing Officer before the scheduled hearing date. A verbal request may be made when the hearing is convened.

b~~c~~) The Hearing Officer may continue or postpone the hearing to another date.~~appeal shall be continued to the next available docket opening, if acceptable to the appellant.~~

~~d) If the request is approved, the Hearing Officer will send the appellant/authorized representative and all interested parties to the appeal a letter (with the original appeal number) rescheduling the hearing. If the postponement is denied, the appellant/authorized representative will be notified in writing as well as all parties to the appeal. If the delay is allowed, the ninety (90) calendar day time limitation of the appeal process is extended by the number of calendar days of allowed delays and all parties to the appeal will be notified in writing.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

2620
2621 **Section 240.465 Dismissal Due to Non-Appearance**
2622
2623 ~~a)~~ ~~If neither the appellant nor the appellant's authorized representative appears at the~~
2624 ~~time and place designated for the hearing, and a postponement has not been~~
2625 ~~requested in writing, the appeal is considered abandoned and is dismissed.~~
2626
2627 a~~b~~) The failure to appear~~refusal~~ by the appellant/authorized representative to proceed
2628 with the hearing is considered a non-appearance. The appeal is considered
2629 abandoned and shall be~~is~~ dismissed.
2630
2631 b~~c~~) Dismissal of an appeal is a final administrative decision. The Department will
2632 make any planned change in services, which had been delayed pending the
2633 outcome of the appeal, immediately upon receipt of written notification from the
2634 Hearing Officer and will notify all parties to the appeal in writing.
2635
2636 c~~d~~) The Department will send a written notice to the appellant/authorized
2637 representative and all parties to the appeal advising that the appeal has been
2638 dismissed for non-appearance.
2639
2640 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
2641
2642 **Section 240.470 Rescheduling the Appeal Hearing**
2643
2644 a) Within ten~~10~~ calendar days after the date of the dismissal notice, the
2645 appellant/authorized representative may submit a written request to reschedule the
2646 appeal hearing. The written request to reschedule the appeal hearing must be sent
2647 to the Hearing Officer~~Section~~ as shown on the dismissal notice~~Dismissal Notice~~
2648 issued by the Hearing Officer. The dismissal will be vacated if good cause can be
2649 shown for the non-appearance that led to the dismissal. Good cause is defined as:
2650
2651 1) Death in the family;
2652
2653 2) Personal injury or illness that reasonably prohibits the appellant from
2654 attending the hearing; or
2655
2656 3) Sudden and unexpected emergencies.
2657
2658 b) If the appeal hearing is rescheduled, a Hearing Officer will send a letter
2659 rescheduling the hearing to the appellant/authorized representative with copies to
2660 all parties to the appeal. The Department shall restore any benefits due the
2661 participant that were terminated or reduced as a result of the dismissal, shall send
2662 a letter so advising to the appellant/authorized representative, and shall send

2663 copies of the letter to all parties to the appeal.
2664
2665 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
2666
2667 **Section 240.475 Recommendations of Hearing Officer**
2668
2669 The Hearing Officer~~hearing officer~~ shall certify the entire record of the hearing to the Director~~ of~~
2670 ~~the Department~~ and shall recommend a decision on each issue in the hearing. The Hearing
2671 Officer~~hearing officer~~ shall not render a final decision relevant to any issue in the hearing.
2672
2673 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
2674
2675 **Section 240.480 The Appeal Decision**
2676
2677 a) The decision resulting from the appeal shall be made in writing no later than 90
2678 calendar days after the Hearing Officer's recommendation.~~close of the hearing~~
2679 ~~record.~~ The appellant/authorized representative and all other parties to the appeal
2680 shall be notified by sending to them a copy of the decision by~~ U.S.~~ mail or email.
2681 The decision shall be made by applying Department rules to the particular case
2682 situation. Appeals shall be considered on a case-by-case basis.
2683
2684 b) The Director shall issue the final administrative~~adminstrative~~ decision shall be
2685 issued by the Director of the Department and it shall either:
2686
2687 1) accept~~uphold~~ or modify the Hearing Officer's recommendation; or~~ in the~~
2688 ~~appeal~~;
2689
2690 2) reject~~not uphold~~ the Hearing Officer's recommendation.~~; or~~
2691
2692 ~~3) determine a lack of Department jurisdiction.~~
2693
2694 c) The decision shall instruct the provider~~vendor~~/CCU/Department to take corrective
2695 action as appropriate.~~ In the event that the participant who is a party to the appeal~~
2696 ~~purchased services not provided by the vendor during the period in which the~~
2697 ~~appeal was conducted, the Department will reimburse the participant under the~~
2698 ~~following conditions:~~
2699
2700 ~~1) the decision rendered by the Department is in favor of the participant in~~
2701 ~~whose behalf the appeal was taken; and~~
2702
2703 ~~2) the appeal was based upon the denial of a request for services.~~
2704
2705 ~~d) Payment shall be authorized only for the level, type and amount of services for~~

~~which payment would have been made through CCP during the same time period. Payment shall not exceed the amount that would have been paid through CCP for the same services.~~

d~~e~~) The decision resulting from the appeal and the recorded transcript shall become a part of the record of the appeal.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.485 Reviewing the Official Report of the Hearing

At any time within 5 years after the date of the release of the Department's final administrative decision, upon written request to the Office of General Counsel, the appellant/authorized representative may review the official report of the hearing.~~ The official report, including documents presented at the proceedings, findings of fact, and findings of law, will be made available by the Department on Aging upon request. The Springfield office of the Department is the only location where the official report of the hearing may be reviewed.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

SUBPART E: REQUEST FOR SERVICES

Section 240.510 Participant Agreement for Community Care Program

If an individual is determined eligible for CCP, he/she or an authorized representative shall sign a written Participant Agreement and Consent Form to request services.

a) Any participant requesting CCP services orally or in writing, shall be contacted by the CCU within five~~5~~ calendar days after the date of the inquiry/request.

b) The signed Participant Agreement and Consent Form will accompany an appropriately completed person-centered comprehensive assessment.

c) The participant/authorized representative shall be informed in writing of eligibility requirements to receive services under CCP and of the participant's right to appeal under this Part.

d) When a participant has a legally appointed guardian, the guardian shall sign the Participant Agreement and Consent Form – Person-Centered Plan of Care. A legally appointed guardian may serve as the "guardian of the person" and/or "guardian of the estate". One legally appointed guardian may serve as guardian of the person while a second legally appointed guardian may serve as guardian of the estate. If two~~2~~ different persons are appointed guardian for an individual, one of

the person and one of the estate, the guardian of the person determines which one is to sign the Participant Agreement and Consent Form.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.540 ~~Statement to be Included on~~ Participant Agreement and Consent Form

A participant must be notified~~The following statement shall be included~~ on the Participant Agreement and Consent Form that:

a) A decision regarding eligibility from CCP services must be made within 30 calendar days of the submission of the Participant Agreement and Consent Form;

b) The participant must be notified in writing the of the decision within 15 calendar days of decision;

c) Services must be provided within 15 calendar days after the notice is sent to the participant; and

d) Any delays attributable to the participant will extend the required time frame.

~~NOTICE~~

~~I understand that a decision regarding my eligibility for Community Care services must be made within 30 calendar days after the date of this completed form. I must be notified in writing of the decision within 15 calendar days after it is made, and I will receive services, if I am eligible, within 15 calendar days after the notice of eligibility is mailed to me. However, any delay I cause in failing to provide information requested by the Department on Aging will extend these time limits.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

SUBPART F: ELIGIBILITY FOR COMMUNITY CARE PROGRAM SERVICES

Section 240.630 Determination of Eligibility

a) A determination of eligibility is an examination of each participant's circumstances to determine the functional need for receipt of CCP, nursing facility, or supported living program provider services. This determination shall consist of analyzing, evaluating and documenting, when necessary, current, full and complete information obtained from the face-to-face comprehensive assessment of the participant in their~~his/her~~ place of residence.

2792 b) The assessment shall include the comprehensive assessment tool and all required
2793 CCP forms authorized by the Department, or any successor assessment tool and
2794 forms used to determine the need for long-term services and supports.
2795
2796 c) A participant's request/services may be denied or terminated when eligibility
2797 criteria are not met, as required by Sections 240.710 through 240.875.
2798
2799 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
2800
2801 **Section 240.655 Redeterminations Process**
2802
2803 Redetermination of CCP shall be conducted by the CCU at least annually; whenever requested
2804 by the participant/authorized representative; or whenever the participant may have experienced a
2805 change in theirhis/her needs that indicates the need for a redetermination to assure continued
2806 eligibility (see Section 240.630).
2807
2808 a) A decision on the redetermination shall be made within 30 calendar days after the
2809 date the redetermination process begins, except as extended by the Department.
2810
2811 b) Redeterminations conducted at the request of the participant/authorized
2812 representative or whenever the participant may have experienced a change in
2813 needs shall be accomplished and a decision rendered within 30 calendar days after
2814 the date of the request for redetermination, except as extended by the Department.
2815
2816 c) The 30 calendar day time limit for completion of a redetermination of a
2817 participant's eligibility shall be extended by any delay caused by the
2818 participant/authorized representative.
2819
2820 1) Participant delay is defined as the number of calendar days a
2821 redetermination of eligibility is delayed because of the
2822 participant's/authorized representative's failure to provide documentation
2823 supporting theirhis/her eligibility or otherwise cooperate as set out in
2824 Section 240.350.
2825
2826 2) In the event that a participant's eligibility cannot be determined due to the
2827 participant's/authorized representative's failure to provide documentation
2828 within 30 calendar days after the date it is verbally requested by the CCU,
2829 the CCU shall extend the time limit for an additional 60 calendar days,
2830 after which services shall be terminated if documentation is not provided.
2831
2832 d) The participant shall maintain eligibility and services shall continue to be
2833 provided throughout the redetermination process unless the participant/authorized
2834 representative delays the process beyond the additional 60 calendar days specified

2835 in subsection (c)(2).
2836
2837 e) Written notification to the participant/authorized representative shall be made as
2838 required by Section 240.945.
2839
2840 f) Any change in services shall be initiated within 15 calendar days after the date the
2841 written notice is mailed or emailed to the participant/authorized representative, as
2842 required by Section 240.945.
2843
2844 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
2845
2846 **Section 240.660 Extension of Time Limit**
2847
2848 The 30 calendar day time limit for completion of a determination of a participant's eligibility
2849 may be extended by any delay caused by the participant.
2850
2851 a) Participant delay is defined as the number of calendar days a determination of
2852 eligibility is delayed because of the participant's/authorized representative's
2853 failure to provide documentation supporting their~~his/her~~ eligibility.
2854
2855 b) In the event that a participant's eligibility cannot be determined due to the
2856 participant's/authorized representative's failure to provide documentation within
2857 90 calendar days after the date of receipt of the completed referral form, the
2858 request for services shall be denied.
2859
2860 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
2861
2862 SUBPART G: NON-FINANCIAL REQUIREMENTS
2863
2864 **Section 240.715 Determination of Need**
2865
2866 a) To be eligible to receive CCP services, a participant shall exhibit a need for
2867 nursing facility, supportive living program, or home and community-based
2868 services. The Determination of Need assessment tool or any successor
2869 assessment tool authorized by the Department specifies the factors that together,
2870 determine the participant's need for long term care or home and community-based
2871 services.
2872
2873 b) The need for long term care is based upon the determined need for a continuum of
2874 in-home and community-based services to prevent inappropriate or premature
2875 placement in a nursing facility.
2876
2877 c) The extent and degree of a participant's need for long term care shall be

determined on the basis of impaired cognitive and functional status as well as the available physical/environmental supports provided to the participant by family, friends or others in the community.

d) The Determination of Need assessment tool consists of two~~2~~ parts:

1) The Mini-Mental State Examination (Folstein, Folstein and McHugh, 1975, no later editions or amendments included) measures cognitive functioning of the participant.

A) The participant who receives a score of 21 or higher shall be considered cognitively intact and zero points shall be added to the Part A, Level of Impairment, score on the Determination of Need assessment tool.

B) The participant who receives a score of 20 or less or who has been diagnosed by a physician or psychiatrist as having dementia, Alzheimer's disease, or organic brain syndrome shall be considered cognitively impaired and ten~~10~~ points shall be added to the Part A, Level of Impairment, score on the Determination of Need assessment tool.

C) Ten additional points shall be added to the Part A, Level of Impairment, score on the Determination of Need assessment tool for the participant who meets the following three~~3~~ criteria:

i) Participant has been adjudicated disabled or incompetent by a Probate Court judge or judge assigned to render a decision on such matters in a court of competent jurisdiction;

ii) a physician or psychiatrist licensed by the State of Illinois has certified that, in their~~his/her~~ professional judgement, the participant suffers from Alzheimer's disease, organic brain syndrome, or dementia; and

iii) a physician or psychiatrist licensed by the State of Illinois has certified that, in their~~his/her~~ professional judgement, the participant requires 24-hour home and community-based services to remain in the home.

2) The Determination of Need assessment tool measures the participant's ability to perform the following activities of daily living (ADLs) and

instrumental activities of daily living (IADLs):

A) Activities of Daily Living

i) Eating

ii) Bathing

iii) Grooming

iv) Dressing

v) Transferring

vi) Incontinence

B) Instrumental Activities of Daily Living

i) Preparing meals

ii) Being alone

iii) Telephoning

iv) Managing money

v) Routine health

vi) Special health

vii) Outside home

viii) Laundry

ix) Housework

e) The Determination of Need assessment scale includes the six~~6~~ ADLs and nine~~9~~ IADLs identified. Each function is scored in two~~2~~ parts: Part A – Level of Impairment, and Part B – Unmet Need for Care.

1) Part A − Level of Impairment, of the Determination of Need assessment tool measures the ability of the participant to perform each ADL and IADL function. A scoring range of zero through three~~3~~ indicates the

degree of impairment of the participant in the performance of ADLs and IADLs.

A) A score of zero for any function indicates that the participant performs or can perform all essential components of the activity, with or without an existing assistive device, such that:

i) no significant impairment of function remains;

ii) activity is not required by the participant (routine health and special health only);

iii) the participant may benefit from but does not require supervision or physical assistance.

B) A score of one~~1~~ for any function indicates that the participant performs or can perform most essential components of the activity, with or without an existing assistive device, but some impairment of function remains such that the participant requires some supervision or physical assistance to accomplish some or all components of the activity. This includes the participant who:

i) experiences minor, intermittent fatigue in performing the activity;

ii) takes longer time to accomplish than an unimpaired person requires; or

iii) must perform the activity more frequently than an unimpaired person.

C) A score of two~~2~~ for any function indicates that the participant cannot perform most of the essential components of the activity, even with an existing assistive device, and requires a great deal of assistance or supervision to accomplish the activity. This includes the participant who:

i) experiences frequent fatigue in performing the activity;

ii) takes an excessive amount of time to perform the activity; or

iii) must perform the activity much more frequently than an

unimpaired person.

D) A score of three~~3~~ for any function indicates that the participant cannot perform the activity and requires someone to perform the task, although the participant may be able to assist in small ways, or requires constant supervision.

2) Part B, Unmet Need for Care, of the Determination of Need assessment tool measures the need of the participant for assistance/performance/supervision for each ADL and IADL function that is not being met by non-CCP resources in the community (e.g., family, friends, local services).

A) A score of zero for any function indicates that there is no impairment, or that the participant's need for assistance is met to the extent that the participant is at no risk to health or safety if additional assistance is not acquired, or that additional assistance will not benefit the participant, or that the participant's needs are being met by non-CCP resources and, therefore, the participant has no need for assistance.

B) A score of one~~1~~ for any function indicates that the participant's need for assistance is met most of the time, but the participant's health and safety are at minimal risk if additional assistance is not acquired.

C) A score of two~~2~~ for any function indicates that the participant's need for assistance is not met most of the time, and the participant's health and safety are at moderate risk if additional assistance is not acquired.

D) A score of three~~3~~ for any function indicates that the participant's need for assistance is rarely, or never, met and the participant's health and safety are at severe risk, which would require acute medical intervention, if additional assistance is not acquired.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.728 Maximum Payment Levels for Person-Centered Plans of Care Including In-home Service

Maximum monthly service dollars are calculated according to the participant's total DON score and approved person-centered plan of care for in-home service or other combination of options,

3050 excluding ADSadult day service. These maximum monthly service dollars will be adjusted by
3051 the Department to be consistent with any future unit rate adjustments for CCP providers and will
3052 be posted and updated on the Department's website.
3053

DON SCORE	SERVICE MAXIMUM LEVEL (Effective on and after January 1, 2022)
29	$ 627
30	701
31	777
32	852
33	926
34	1,002
35	1,077
36	1,150
37	1,226
38	1,301
39	1,375
40	1,451
41	1,526
42	1,599
43	1,676
44	1,750
45	1,827
46	1,899
47	1,975
48	2,051
49	2,123
50	2,200
51	2,275
52	2,350
53	2,424
54	2,496
55	2,573
56	2,648
57	2,725
58	2,797
59	2,874
60	2,949
61	3,022
62	3,098
63	3,174
64	3,247
65	3,322

~~66~~	~~3,399~~
~~67~~	~~3,471~~
~~68~~	~~3,547~~
~~69~~	~~3,622~~
~~70~~	~~3,696~~
~~71~~	~~3,772~~
~~72~~	~~3,847~~
~~73~~	~~3,920~~
~~74~~	~~3,997~~
~~75~~	~~4,071~~
~~76~~	~~4,147~~
~~77~~	~~4,221~~
~~78~~	~~4,296~~
~~79~~	~~4,372~~
~~80~~	~~4,444~~
~~81~~	~~4,521~~
~~82~~	~~4,596~~
~~83~~	~~4,671~~
~~84~~	~~4,745~~
~~85~~	~~4,822~~
~~86~~	~~4,895~~
~~87~~	~~4,969~~
~~88~~	~~5,046~~
~~89~~	~~5,118~~
~~90~~	~~5,195~~
~~91~~	~~5,270~~
~~92~~	~~5,343~~
~~93~~	~~5,419~~
~~94~~	~~5,495~~
~~95~~	~~5,568~~
~~96~~	~~5,643~~
~~97~~	~~5,720~~
~~98~~	~~5,792~~
~~99~~	~~5,868~~
~~100~~	~~5,944~~

3054
3055 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
3056
3057 **Section 240.729 Maximum Payment Levels for Person-Centered Plans of Care Including**
3058 **Adult Day Service**
3059
3060 Maximum monthly service dollars are calculated according to the participant's total DON score
3061 and approved person-centered plan of care for ADS~~adult day service~~ or other combination of

3062 options including ADSadult day service. These maximum monthly service dollars will be
3063 adjusted by the Department to be consistent with any future unit rate adjustments for CCP
3064 providers and will be posted and updated on the Department's website.
3065

DON SCORE	SERVICE MAXIMUM LEVEL (Effective on and after January 1, 2022)
29	$ 1,284
30	1,493
31	1,717
32	1,937
33	2,161
34	2,382
35	2,518
36	2,652
37	2,786
38	2,920
39	3,055
40	3,191
41	3,325
42	3,460
43	3,595
44	3,729
45	3,865
46	4,000
47	4,135
48	4,268
49	4,403
50	4,538
51	4,673
52	4,809
53	4,941
54	5,076
55	5,212
56	5,344
57	5,481
58	5,615
59	5,750
60	5,884
61	6,019
62	6,154
63	6,287
64	6,424
65	6,557

~~66~~	~~6,693~~
~~67~~	~~6,830~~
~~68~~	~~6,961~~
~~69~~	~~7,098~~
~~70~~	~~7,233~~
~~71~~	~~7,367~~
~~72~~	~~7,502~~
~~73~~	~~7,637~~
~~74~~	~~7,771~~
~~75~~	~~7,905~~
~~76~~	~~8,041~~
~~77~~	~~8,175~~
~~78~~	~~8,311~~
~~79~~	~~8,445~~
~~80~~	~~8,578~~
~~81~~	~~8,714~~
~~82~~	~~8,849~~
~~83~~	~~8,983~~
~~84~~	~~9,118~~
~~85~~	~~9,254~~
~~86~~	~~9,386~~
~~87~~	~~9,522~~
~~88~~	~~9,656~~
~~89~~	~~9,789~~
~~90~~	~~9,926~~
~~91~~	~~10,059~~
~~92~~	~~10,196~~
~~93~~	~~10,332~~
~~94~~	~~10,463~~
~~95~~	~~10,600~~
~~96~~	~~10,735~~
~~97~~	~~10,870~~
~~98~~	~~11,004~~
~~99~~	~~11,138~~
~~100~~	~~11,273~~

3066
3067 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
3068
3069 **Section 240.730 Person-Centered Plan of Care**
3070
3071 a) A person-centered plan of care will be developed using the person-centered
3072 planning process in accordance with Section 240.550.
3073

b) The person-centered plan of care, and any subsequent revisions, shall be written in plain language and shall reflect the participant's goals, preferences and desired outcomes, indicating services and supports important to the participant, based upon the functional needs identified by the comprehensive assessment, including:

1) a description of the conditions that directly correspond to the assessed functional needs, including:

A) the strengths and preferences of the individual, and resources available to that individual~~him/her~~;

B) the clinical and support needs as identified through a comprehensive assessment of functional needs;

C) paid and unpaid services and supports that will assist the participant to achieve identified goals, and natural supports and vendors available to meet those needs;

D) risk factors and measures in place to minimize harm, including possible interventions that may be used if aid is necessary for adherence to program requirements, and the customized strategies and back-up plans to minimize any risk factors for the individual;

E) identification of the Care Coordinator and other individuals/vendors responsible for monitoring the person-centered plan of care;

F) any measures that will be used to support how to evaluate the effectiveness of the services and supports; and

G) the time limits for periodic reviews to determine if services and supports are still appropriate, need to be modified, or can be terminated.

2) a summary of the alternatives and settings considered by the participant/authorized representative and their~~his/her~~ final selections of services, supports and providers/vendors as reinforcement that the right of freedom of choice may be exercised.

A) The CCU will list all providers or programs in the service area and document the available options discussed with the participant/authorized representative.

B) The CCU will also afford the participant/authorized representative an opportunity to visit all of the adult day facilities in their~~his/her~~ service area before finalizing any selections.

3) an acknowledgement of informed consent by the participant/authorized representative.

c) Services are to be offered to each participant who meets the minimum required scores on the DON; who meets all other eligibility requirements; for whom an adequate person-centered plan of care has been developed; and whose service costs are within the allowable maximums. Care coordinators and participants/authorized representatives shall develop the person-centered plan of care in the best interest of the participant/authorized representatives, based on services selected by the participants/authorized representatives from among those available in the community. Maximum monthly service dollars are only available to fund services provided through the CCP.

d) If a person-centered plan of care cannot be developed that adequately meets the participant's needs within the allowable maximums for cost of service, CCP services shall be denied or services terminated, as appropriate to the case.

e) Each participant/authorized representative must be advised by the CCU of their~~his/her~~ right to refuse the offered services, to choose to enter a long-term care facility or to choose neither.

f) The allowable monthly cost for services provided to an eligible participant and paid for through the CCP cannot exceed the maximum monthly cost as determined by the score attained on the CCP DON that is determined by the CCU based on current, full and complete information on the specific needs of the participant. A person-centered plan of care shall be based upon the number of days in a month.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.740 Assessment of Need

a) The CCP comprehensive assessment tool and determination of need for CCP services shall be administered by CCU care coordinators or Department personnel who are technically competent persons certified by the Department to conduct the comprehensive assessment and determinations of need.

b) The certification shall result from the successful completion of training, which includes, but is not limited to, the following topics.

1) financial eligibility determination (see Sections 240.800 through 240.875);

2) administration of the DON (see Section 240.715);

3) person-centered plan of care development and implementation;

4) performance of Choices for Care screenings (see Section 240.1010); and

5) form utilization and flow.

c) Scoring of the CCP DON shall be accomplished without regard to the capability of CCP providers~~vendors~~ to totally meet the determined needs of the participant.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.741 Prerequisites for Automated Medication Dispenser Service

a) Authorization for the AMD service is determined based on a participant's need for the service, including the participant's medication, medical, cognitive and physical needs that indicate the potential to benefit from the AMD service.

b) To be authorized for the service, the participant must:

1) meet all of the following criteria:

A) eligibility for CCP services;

B) take one~~1~~ or more medications that necessitate the medications be taken at a set schedule to avoid complications;

C) have the potential to benefit from the service, understand the need to take medications, respond to alerts to take medication and is physically able to take medication independently from the AMD unit;

D) designate an assisting party to assist with the AMD unit and medications; and

E) commit to using the AMD unit appropriately; and

2) exhibit at least one~~1~~ of the following issues or diagnoses:

A) a history of non-adherence to treatment, medication or therapy regimens;

B) resides alone or lacks assistance from others to assist with regular medication administration;

C) impaired motor function that causes difficulty in handling medication receptacles and small pills;

D) attempts at using less costly alternatives (e.g., pill reminders, medication organizers with alarms and telephone reminders/prompts) have failed;

E) recent transition from a more restrictive care setting, such as a hospital or nursing facility;

F) has a diagnosis of cognitive impairment;

G) has a diagnosis of diabetes;

H) has a diagnosis of congestive heart failure;

I) has a diagnosis of hypertension;

J) has a diagnosis of depression/mental illness; or

K) has a diagnosis of cancer.

c) Other criteria may be developed by the Department to assist in determining what is the most appropriate AMD system to meet the participant's needs.

d) The participant/authorized representative and/or the assisting party shall complete documentation acknowledging that the AMD was installed. Whenever possible, the assisting party should be present during the AMD installation.

e) The assisting party must complete documentation requested by the Department agreeing that ~~he/she/~~they will be responsible for:

1) administration and oversight of the participant's medications;

2) manually filling or arranging for another person, who could be the participant, to fill the AMD unit in accordance with prescribing instructions;

3) working with the AMD provider to program the dispenser for the initial medication schedule and subsequent changes;

4) using best efforts to ensure no illegal substances are placed in the AMD unit;

5) serving as a point of contact for the AMD provider and taking reasonable and necessary actions based on any notifications of missed medication doses and other system issues;

6) receiving and understanding the instructions and demonstration given by the AMD provider for the AMD equipment;

7) understanding how to access reports about the unit and medication regimen and contacting the AMD provider when medication schedules are changed; and

8) providing reasonable advance notice to the AMD provider, CCU, and participant/authorized representative if unable to continue acting as the assisting party.

f) A participant/authorized representative will be responsible for damages to or loss of the AMD equipment unless a law enforcement report of theft has been filed.

1) The provider will document the damages/loss of equipment.

2) One documented occurrence of damages/loss of equipment may be cause for a MOU or~~suspension of the participant's AMD services pending~~ termination, in accordance with the Participant Agreement and Section 240.350.~~ The provider will verbally advise the CCU on the same day, if possible, but not later than the next work day after the date of the occurrence. A written report, including, at a minimum, the names of the participant and the worker and the date of the occurrence, will be submitted by the provider to the CCU within 2 work days after the date of the occurrence. The written report may be submitted in person or through mail, facsimile or electronic means.~~

~~3) Upon receipt of the written report documenting the occurrence of damages/loss of equipment, the CCU may suspend the participant's AMD services in accordance with Section 240.930. The date of suspension may be the date of the occurrence of damages to or loss of equipment.~~

3289 g) Whenever an assisting party can no longer meet the obligations set out in
3290 subsection (e), it is the responsibility of the participant/authorized representative
3291 to identify a new assisting party and cooperate with arrangements for that
3292 individual to be trained by the AMD provider. Notification of the change shall be
3293 communicated to the AMD provider and the CCU before the change is made.
3294
3295 h) An assisting party cannot be an individual or entity providing other services under
3296 CCP, such as an in-home service provider.
3297
3298 i) Failure to have a current assisting party designation may result in the participant's
3299 termination from the AMD service~~, in accordance with Section 240.930~~.
3300
3301 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
3302
3303 **Section 240.755 Residence**
3304
3305 a) To be eligible for CCP, a participant must be a resident of the State of Illinois as
3306 defined in Section 2-10 of the Public Aid Code [305 ILCS 5].
3307
3308 b) Only those persons who are legally admitted to the U.S. can be found to be
3309 residents of the State of Illinois. The residency of a participant is based on one~~1~~ of
3310 the following factors:
3311
3312 1) A participant whose residence is located in Illinois, but whose U.S. Post
3313 Office address indicates a state other than Illinois (i.e., a participant
3314 residing near the State line), is a resident of Illinois;
3315
3316 2) An individual currently living in Illinois and receiving a State
3317 Supplementary Payment (as defined in 42 CFR 435.4), Mandatory State
3318 Supplement or Optional State Supplement from a different state, is not a
3319 resident of Illinois for purposes of CCP eligibility;
3320
3321 3) A participant who is incapable of stating their~~his/her~~ intent to remain in
3322 Illinois is a resident of Illinois if they~~he/she~~ currently lives in Illinois.
3323
3324 c) The Department~~Illinois~~ cannot deny eligibility to a participant who, although
3325 currently residing in Illinois, has not lived in this State for a specific period of
3326 time. An Illinois resident who is temporarily absent from the State retains Illinois
3327 residency if the individual intends to return to Illinois when the reason for the
3328 absence is accomplished. If an individual remains outside of Illinois for a
3329 continuous period of more than 12 months, they~~he/she~~ will provide evidence (e.g.,
3330 a copy of their~~his/her~~ most recent State Income Tax return) documenting that the
3331 absence was not due to an intent to change their~~his/her~~ residency.

d) The Department~~Illinois~~ cannot deny eligibility to a participant who is temporarily absent from Illinois and plans to return when the purpose of his/her absence has been completed unless the absence will exceed 60 calendar days or unless the other state has determined that the participant is a resident of that state.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.760 Social Security Number

a) To be eligible for CCP, each participant must furnish a Social Security Number (SSN). If more than one~~1~~ SSN has been used by a participant, then all SSNs are to be furnished.

b) If any CCP participant does not have an SSN, the Department or CCU shall assist them~~him/her~~ in making the application.

c) CCP services will not be denied, delayed or discontinued pending the issuance or validation of an SSN if the participant has applied for the SSN.

d) Participants who refuse to furnish an SSN, and/or apply for an SSN when requested, are ineligible for CCP.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

SUBPART H: FINANCIAL REQUIREMENTS

Section 240.810 Assets

a) To be eligible to receive CCP services, a participant shall not own interest in non-exempt assets having a combined value in excess of $17,500, if:

1) unmarried; or

2) married and:

A) spouse is receiving CCP services;

B) spouse is in a nursing facility;

C) spouse does not reside on a permanent basis with, and does not receive support from or give support to, the participant;

3375 D) spouse is abandoned; or
3376
3377 E) spouse is potentially abusing the participant.
3378
3379 EXCEPTION: A participant, who is married and the spouse does not receive
3380 CCP services, shall not own interest in non-exempt assets having a total value in
3381 excess of the asset disregard amount allowed by HFS for Medicaid in a pre-paid
3382 burial plan or life insurance policy + burial merchandise. Non-exempt assets
3383 having value over the asset disregard amount up to the amount allowed by the
3384 Community Spouse Asset Allowance, as adopted by HFS at 89 Ill. Adm. Code
3385 120.379(d), must be transferred to or for the sole benefit of the community
3386 spouse. If the couple owns assets that exceed the asset disregard and prevention
3387 of spousal impoverishment amounts allowed by statute, the excess (up to the
3388 amount of non-exempt assets allowed after transfer, and/or up to the amount of
3389 countable monthly income allowed after diversion) shall be designated as a spend
3390 down, to be spent before Medicaid enrollment is established.
3391
3392 b) The value of non-exempt assets shall be considered in determining eligibility for
3393 CCP.
3394
3395 c) All assets not specifically exempt are non-exempt.
3396
3397 d) When a participant's non-exempt assets are greater than the allowable disregard as
3398 specified in subsection (a), consideration of non-liquid assets may be deferred as
3399 follows:
3400
3401 1) real property may be deferred from consideration for six~~6~~ months;
3402
3403 2) the participant shall sign an agreement to dispose of the real property in
3404 excess of the allowable disregard within six~~6~~ months after the date of the
3405 agreement; and
3406
3407 3) the six~~6~~-month period for disposition may be extended an additional six~~6~~
3408 months if the participant fails to dispose of the asset (through no fault of
3409 their~~his/her~~ own) despite reasonable and diligent effort.
3410
3411 (Source: Amended at 48 Ill. Reg. _______, effective _____________)
3412
3413 **Section 240.820 Asset Transfers**
3414
3415 a) The following transactions are considered transfers of assets:
3416
3417 1) when a participant buys, sells or gives away real or personal property; or

2) if the participant changes the way real or personal property is held.

b) Transfers of assets that are exempt at the time of transfer do not affect eligibility.

c) Transfers of non-exempt assets completed within 60 months before the date of request for CCP services shall be considered in determining eligibility. If a fair market value was not received, the value of the transferred asset shall be considered toward non-exempt assets and any excess amount shall be considered available to meet service costs unless it is proven that the participant did not transfer the property to qualify for or increase the need for CCP.

1) If real property was transferred, fair market value is to be determined by use of statements from reputable realtors or other community members recognized as knowledgeable of property value (e.g., bankers, tax assessors, auctioneers).

2) If personal property was transferred, fair market value is to be determined by use of a statement from an institution having knowledge of the property at the time of the transfer, or from an individual who has specific knowledge of the transfer and/or the value of the asset at the time of the transfer.

3) Factors to be considered when determining whether a transfer of property was made to qualify for or increase the need for CCP include but are not limited to:

A) the participant's physical and mental condition at the time of transfer;

B) the participant's financial situation at the time of transfer;

C) the participant's need for services at the time of transfer;

D) changes in the participant's living arrangements at the time of transfer; and

E) how soon after the transfer the participant applied for services.

d) If after consideration of these factors the participant is ineligible, the period of ineligibility begins at the date of request for services for participants and the date of termination for participants. The period of ineligibility lasts from the initial date for as long as the asset would meet the cost of CCP services if it were

available to the participant, but in no case shall it last longer than 60 months after the date of transfer.

e) A participant determined ineligible under subsection (d) may become eligible if the following occurs:

1) the property is reconveyed to the participant; or

2) an adequate consideration is paid to the participant.

f) It shall be the responsibility of a participant to report all property transfers to the CCU within five~~5~~ days after the date of the transaction.

g) If an unreported transfer of property was made by a participant within 60 months prior to the date of request for services or was made after the submission of the request for services but before CCP services were authorized, and services to which the participant was not entitled were received as a result of the failure to report the transfer, services shall be terminated.

h) Involuntary transfers do not affect eligibility.

i) When the property transfer was made to obtain support or care, and the terms of the agreement are being met, only those needs not included in the agreement may be met through CCP.

j) Transfers because of separation, divorce or other settlement shall not affect eligibility if:

1) they are court ordered; or

2) if there is no court order and the participant and their~~his/her~~ spouse divide the property in half.

k) Transfers from an individual bank account to a joint bank account do not affect eligibility if the participant retains access to the money and the money continues to be used for the participant's needs.

l) Income tax refunds are available assets. If the refund is based on a joint income tax return, one-half of the refund is to be considered as belonging to the participant.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.825 Income

a) Documentation of all currently available income that is not specified as exempt shall be provided during the participant's determination/redetermination of eligibility for CCP.

b) In accordance with provisions of 89 Ill. Adm. Code 120.379, a participant whose spouse (i.e., community spouse) is not receiving CCP services may divert income to their~~his/her~~ spouse so that the spouse may have exempt income up to the amount exempted by HFS (see 89 Ill. Adm. Code 120.379(e)) for a community spouse.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.830 Unearned Income Exemptions

Unearned income is all income other than that received in the form of salary or wages for services performed as an employee or profits from self-employment.

a) The following unearned income shall be exempt from consideration in determining eligibility:

1) Any allotment under SNAP (7 U.S.C.~~USC~~ 2017(b));

2) The value of the U.S. Department of Agriculture donated foods (surplus commodities);

3) Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (42 U.S.C.~~USC~~ 4636);

4) Any per capita judgment funds paid under Public Law 92-254 to members of the Blackfeet Tribe of the Blackfeet Indian Reservation, Montana and Gros Ventre Tribe of the Fort Belknap Reservation, Montana (25 U.S.C.~~USC~~ 1264);

5) Any benefits received under Title III, Nutrition Program for the elderly, of the Older Americans Act of 1965, as amended (42 U.S.C.~~USC~~ 3030(e));

6) Any compensation provided to individual volunteers under the Retired Senior Volunteer Program (42 U.S.C.~~USC~~ 5001) and the Foster Grandparent Program (42 U.S.C.~~USC~~ 5011) and Older Americans Community Service Programs (42 U.S.C.~~USC~~ 3056) established under Title II of the Domestic Volunteer Service Act, as amended (42

U.S.C.~~USC~~ 5001 through 5023);

7) Income in an amount not greater than the current amount allowed received by a beneficiary of life insurance which is expended on the funeral and burial of the insured;

8) Income received under Section 4(c) of the Senior Citizens and Persons with Disabilities Property Tax Relief Act. This includes both the benefits commonly known as the "circuit breaker" and "additional grants";

9) Payments to volunteers under the 1973 Domestic Volunteer Service Act (48 U.S.C.~~USC~~ 5044(q)). These include:

   A) Vista Volunteers;

   B) volunteers serving as senior health aides, senior companions, or foster grandparents;

   C) persons serving in the Service Corps of Retired Executives (SCORE) or the Active Corps of Executives (ACE);

10) Social Security death benefits expended on a funeral/burial;

11) The value of home produce that is used for personal consumption;

12) The value of supplemental food assistance received under the Child Nutrition Act of 1966, as amended, (42 U.S.C.~~USC~~ 1780(b)) and the special food service program for children under the National School Lunch Act, as amended (42 U.S.C.~~USC~~ 1760);

13) Any payments distributed per capita or held in trust for members of any Indian tribe under Public Law 92-254, 93-134 or 94-450 (25 U.S.C.~~USC~~ 1407);

14) Tax exempt portions of payments made pursuant to the Alaska Native Claims Settlement Act (43 U.S.C.~~USC~~ 1626);

15) Experimental Housing Allowance Program payments made under Annual Contributions Contracts entered into prior to January 1, 1975 under Section 23 of the U.S. Housing Act of 1937, as amended (42 U.S.C.~~USC~~ 1437(f));

16) That portion of an educational benefit that is actually used for items such

as tuition, books, fees, equipment or transportation, necessary for school attendance:

A) Veterans Educational Assistance –
Income from educational benefits paid to a veteran or to a dependent of a veteran shall be exempt only to the extent that it is applied toward educational expenses;

B) Social Security Administration (SSA) Benefits –
Income received as a SSA benefit paid to or for an individual and conditioned upon the individual's regular attendance in a school, college or university, or a course of vocational or technical learning, shall be exempt to the extent that it is applied toward educational expenses;

C) Loan and Grants –
Income from educational loans and grants obtained and used under conditions that prevent their use for current living costs shall be exempt;

17) Income from educational loans and grants made or insured under any program administered by the Secretary of Education is totally exempt whether the grant is paid directly to the schools or to the student. These loans and grants include the National Direct Student Loans, Basic Educational Opportunity Grants, Supplementary Educational Opportunity Grant, Work Study Grant, and the Guaranteed Loan Program;

18) The following incentive allowances:

A) National Training Services Grant –
Incentive payments which the Department of Rehabilitation Services authorizes to be paid for a maximum of two~~2~~ years to disabled persons receiving categorical public assistance and enrolled in the National Training Service Project;

B) Jobs Training Partnership Act (JTPA) –
Needs based payments (e.g., transportation); case assistance (e.g., uniforms and lunches); compensations in lieu of wages; and allowances received under JTPA are exempt.

b) Unearned Income In-Kind

1) Unearned income in-kind is payment made by a person other than a

member of a participant's family on behalf of or in the name of a member of the participant's family (e.g., payment of CCP incurred expense for care, medical bills, etc.).

2) Unearned income in-kind shall be exempt.

3) When the participant's family shares a dwelling unit with another family or individuals, the exchange of cash for purposes of satisfying payment of shelter related obligations shall not constitute an income in-kind payment and shall not be considered available to the person who receives and disburses the shelter-related payment.

c) Earmarked Income

1) Earmarked income is income restricted for the use of a specified participant by court order or by legal stipulation of a contributor.

2) Earmarked income shall be considered as income of the specified participant only.

d) Lump Sum Payments

1) Lump sum payments shall be considered available for the eligibility period in which it is received and are not exempt.

2) Supplemental Security Income (SSI) lump sum payments are exempt income. SSI lump sum payments that are kept separately and are not combined with other monies remain exempt.

e) Protected Income
SSI is protected income and not considered available to be applied toward the incurred expense for CCP services of anyone other than the SSI recipient.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.845 Family

For purposes of this Subpart, family means the participant, their~~his/her~~ spouse or partner in a civil union if residing in the same household, and any persons declared by the participant and spouse or civil union partner, if applicable, as dependents for federal income tax purposes. Any income received by any family member shall be considered family income.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.850 Monthly Average Income

Income to be received on a monthly basis during the twelve ~~(12)~~ month period is to be added to the total amount of income received during the previous twelve ~~(12)~~ months from irregular (other than monthly) sources: e.g., farm, interest and/or dividend income. The total amount of income thus determined is to be divided by twelve ~~(12)~~ to arrive at the monthly average.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

SUBPART I: DISPOSITION OF DETERMINATION

Section 240.905 Prohibition of Institutionalized Individuals From Receiving Community Care Program Services

a) CCP services shall not be provided to:

1) any participant who is eligible for those services while an in-patient of any institution that is subject to licensure as required by the ~~Illinois~~ Nursing Home Care Act [210 ILCS 45].

2) any individual residing in a public institution (see 42 CFR 435.1009).

3) any individual confined or detained in any local or State penal or correctional institution or by a federal law enforcement agency.

b) A resident of a private institution who has a contract with the institution providing total needs throughout life is ineligible for this program, as no needs remain to be met.

c) A resident of a private institution (other than those who have purchased life care contracts) is ineligible for this program when he/she has purchased care and maintenance to provide for all their~~his/her~~ needs in the institution and the amount paid has not been wholly consumed for care.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.910 Written Notification

Each participant requesting CCP services shall receive written notification of eligibility or ineligibility to receive CCP services.

a) Written notification shall be sent to the participant/authorized representative

3719 within 15 calendar days after the date of the completed determination of
3720 eligibility.
3721
3722 b) If the participant has not received a homecare aide within 15 days of the Notice of
3723 Eligibility, the participant/authorized representative may find their own homecare
3724 aide in accordance with Section 240.270. Payment for those services shall be
3725 issued a manner determined by the Department. The Notice of Eligibility must
3726 contain a statement informing the participant/authorized representative of this
3727 right.~~The written notification shall contain the following statement:~~
3728
3729 ~~NOTICE~~
3730
3731 ~~If you have been found eligible for Community Care services, you should begin~~
3732 ~~receiving services within 15 calendar days after the date of this Notice. If a~~
3733 ~~homecare aide has not come to help you within 15 calendar days, you can hire~~
3734 ~~your own homecare aide (including a friend or relative) to provide the amount and~~
3735 ~~type of Community Care services specified in this Notice. The Department on~~
3736 ~~Aging will pay the homecare aide you have hired to the extent authorized by the~~
3737 ~~CCP Participant Agreement. Payment shall continue until the Department's~~
3738 ~~approved provider initiates provision of Community Care services to you.~~
3739
3740 c) If it is necessary for the participant/authorized representative to hire their~~his/her~~
3741 own homecare aide due to the failure of the authorized provider to provide CCP
3742 services within 15 calendar days, the temporary services and payment for those
3743 services shall terminate immediately upon initiation of service provided by a CCP
3744 approved provider. (See Section 240.1580(c).)
3745
3746 d) If a participant is determined ineligible and request for CCP services is denied, the
3747 written notification shall be sent to the participant/authorized representative by
3748 ~~certified~~ mail, email~~return receipt requested~~, or given to the participant/authorized
3749 representative personally, in which case the participant/authorized representative
3750 shall provide a signed and dated receipt for the notice. The notice shall clearly
3751 state the reason for the denial and shall advise the participant/authorized
3752 representative of their~~his/her~~ right to appeal the decision.~~ (See Section 240.400.)~~
3753
3754 ~~e) If a participant is denied because of death, the notice may be sent by regular mail.~~
3755
3756 e~~f~~) The date of the written notice of eligibility or ineligibility shall be the same date
3757 as the date of mailing or emailing. The provider shall be notified on the same
3758 date ~~of mailing~~ as the participant.
3759
3760 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
3761

Section 240.915 Service Provision

If a participant is determined eligible for CCP, services shall be provided in accordance with the person-centered plan of care within 15 calendar days after the date of the notification of eligibility~~, as required by Section 240.910,~~ unless delayed by the participant/authorized representative.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.920 Reasons for Denial

Denial of CCP eligibility shall be based upon one~~1~~ or more of the reasons identified in this Section:

a) Participant is less than 60 years of age at the time of the determination of eligibility.

b) Participant is not in need of CCP services: scored less than 29 total points/less than 15 points on Part A, Level of Impairment, of the DON.

c) Participant/legal guardian/authorized representative refuses to sign the Participant Agreement – Person-Centered Plan of Care.

d) Participant/authorized representative does not agree with the person-centered plan of care/hours of service and an agreement could not be reached during the person-centered planning process.

e) Participant is deceased.

f) Participant has been institutionalized or is not otherwise available for services for more than 60 calendar days after the date of referral.

g) Participant/authorized representative voluntarily withdraws a request.

h) Participant cannot be located to determine eligibility for or to provide CCP services.

i) Participant/authorized representative has not provided reasonable documentation supporting eligibility as required by the Department or its CCU within 90 calendar days after the date of receipt of referral.

j) Participant/authorized representative has not cooperated with the Department/CCU/provider~~vendor as required and as specified by Section~~

3805 ~~240.350~~.
3806
3807 k) Participant does not meet citizenship requirements.
3808
3809 l) Participant does not meet residency requirements.
3810
3811 m) The CCU determines that an adequate person-centered plan of care cannot be
3812 developed that adequately meets the participant's determined needs under Section
3813 240.715.
3814
3815 n) The total value of participant's non-exempt assets is in excess of $17,500.
3816
3817 o) Eligibility could not be established for a participant who was receiving interim
3818 services based upon presumptive eligibility ~~as required by Sections 240.1020 and~~
3819 ~~240.865~~.
3820
3821 p) Participant/authorized representative provided fraudulent information.
3822
3823 q) Participant whose request for CCP services was previously denied or whose
3824 services were terminated for non-cooperation as set forth in Section 240.350 or
3825 240.255 shall be denied services upon a subsequent request for services, unless
3826 the situation or condition that led to MOU~~the memorandum of understanding (see~~
3827 ~~Section 240.350)~~ has been permanently resolved.
3828
3829 r) Participant/authorized representative refuses to sign the Participant Agreement
3830 and Consent Form. ~~in accordance with Section 240.330~~
3831
3832 s) Participant/authorized representative has transferred non-exempt assets or failed
3833 to report a transfer within the past 60 months for the purpose of obtaining CCP
3834 services.
3835
3836 t) Participant/authorized representative has not reported or refused to provide
3837 documentation of changes in circumstances that have occurred prior to eligibility
3838 determination ~~as required by Section 240.360~~.
3839
3840 u) Participant/authorized representative refuses to apply for and, if eligible, enroll in
3841 medical assistance under Article V of the Illinois Public Aid Code ~~as required by~~
3842 ~~Section 240.865~~.
3843
3844 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
3845
3846 **Section 240.930 Memorandum of Understanding~~Suspension of Services~~**
3847

3848 a) A provider may request a MOU from the~~CCP services may be suspended by a~~
3849 CCU when a participant has not cooperated with the provider~~vendor~~ in the
3850 provision of services as set forth in Section 240.350.~~ Services shall be reinstated~~
3851 ~~when the participant has met and continues to meet the requirements in the~~
3852 ~~memorandum of understanding (MOU) (see Section 240.350).~~
3853
3854 b) When determining if a MOU is appropriate, the provider and CCU must consider
3855 whether the participant's behavior is due to a diminished mental capacity or
3856 mental illness and the participant's ability to comply with the terms of the MOU.
3857 Prior to the issue of a MOU, the CCU must document efforts to resolve the
3858 conflict in coordination with the participant and the provider.~~The vendor shall~~
3859 ~~notify the CCU of the need for suspension in accordance with Section 240.350.~~
3860
3861 c) Upon receipt of the provider's~~vendor's~~ verbal request for a MOU~~suspension~~, the
3862 CCU shall immediately, but not later than the next work day, begin the process of
3863 preparing the MOU.~~verbally advise the participant of the suspension and the date~~
3864 ~~of the suspension of services. This date shall be the date the vendor left or was~~
3865 ~~unable to render service.~~
3866
3867 d) A MOU must include a detailed account of the actions or behaviors that resulted
3868 in the need for a MOU and outline the corrective steps that the participant needs
3869 to take to address the actions or behaviors.~~Notification of the suspension of~~
3870 ~~services shall be sent to the participant /authorized representative and the vendors~~
3871 ~~by the CCU by regular mail within 5 calendar days after the verbal notification by~~
3872 ~~the CCU to the participant.~~
3873
3874 e) The CCU must provide the participant with a copy of the MOU in their primary
3875 language.~~, in accordance with Section 240.350, shall obtain the signature of all~~
3876 ~~parties to the MOU within 30 calendar days after the effective date of suspension.~~
3877
3878 f) A copy of the executed MOU must be provided to the participant/authorized
3879 representative by mail or email. A copy shall be placed in the participant's
3880 file.~~Upon execution of the MOU (see Section 240.160), reinstatement of service~~
3881 ~~shall be authorized in writing by the CCU, to be effective on or before 15 calendar~~
3882 ~~days after the date of the last signature on the MOU. The written notice shall be~~
3883 ~~provided to the participant and vendors by regular mail.~~
3884
3885 g) The CCU must complete an annual review of each MOU it has issued. The CCU
3886 must determine if the participant has successfully complied with the terms of the
3887 MOU and if the MOU should be terminated. The CCU must send the participant a
3888 letter detailing its decision to terminate or renew the MOU. The decision to renew
3889 a MOU may be appealed by the participant/authorized representative.~~Suspension~~
3890 ~~of services may not be appealed because a suspension is not a final decision.~~

3891
3892 h) A MOU does not automatically transfer when a participant transfers to a new
3893 provider or CCU. The CCU must review the participant's case file and determine
3894 if a MOU is still necessary. If the CCU determines that a MOU is necessary, a
3895 new agreement must be executed.
3896
3897 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
3898
3899 **Section 240.940 Penalty Payments (Repealed)**
3900
3901 The Department shall pay $100 to each eligible participant to whom a Notice of Eligibility is not
3902 mailed within 45 calendar days after the date on which eligibility is determined, as defined in
3903 Section 240.510, by the Department or a CCU. It shall be the responsibility of the
3904 participant/authorized representative to notify the Department in writing when this occurs.
3905
3906 (Source: Repealed at 48 Ill. Reg. ______, effective ____________)
3907
3908 **Section 240.945 Notification of a Change in Service**
3909
3910 a) Any participant whose CCP services are being changed in the following manner
3911 shall be advised of the change by written notice: change of service type; reduced
3912 amount of service; increased amount of services; or termination.
3913
3914 1) The written notice shall be sent to a participant/authorized representative
3915 by certified mail, emailreturn receipt requested, or given personally., in
3916 which case the participant/authorized representative is to provide a signed
3917 and dated receipt for the notice, except for instances involving automatic,
3918 non-discretionary changes in eligibility, rates or benefits required by
3919 federal or State statute or regulation. In these instances, regular mail is
3920 acceptable. Also, in the event of the death of a participant, regular mail is
3921 acceptable for notification purposes.
3922
3923 2) The notice shall clearly state the reason for the action being taken.
3924
3925 3) The participant/authorized representative shall be notified of the action
3926 being taken no later than 15 calendar days after the date of assessment or
3927 redetermination and the action shall be effective no sooner than 15
3928 calendar days after the date of the notice if the action is adverse to the
3929 participant (see Section 240.160 for a definition of adverse action). This
3930 time frame does not apply to termination as a result of the non-cooperative
3931 act specified in Section 240.355240.350(b)(1).
3932
3933 4) In instances involving an automatic, non-discretionary change in

eligibility, rates or benefits required by federal or State statute or regulation, the participant/authorized representative will be notified of the action being taken at least 15 calendar days prior to the implementation by the CCU of the change affecting the participant. The action will be effective no sooner than 15 calendar days after the date of notice if the action is adverse to the participant.

5) In the event of a death, the termination shall be effective the date of the participant's death. The form shall be dated and mailed/hand-delivered upon the Department or the CCU being informed of the death.

b) CCP services may be changed, reduced or terminated at the request of the participant/authorized representative and do not require the 15-calendar day notice period under the following circumstances:

1) the participant/authorized representative provides the CCU with a signed statement that the change, reduction or termination is at their~~his/her~~ request;

2) the CCU, participant/authorized representative and provider mutually agree to the initiation of the change, reduction or termination on the agreed upon date (which may be less than the required 15 calendar days after the date of the notice to the participant/authorized representative);

3) a written notice is provided to the participant/authorized representative ~~(either by certified mail, return receipt requested, or handed to the participant/authorized representative, with a receipt provided by the participant/authorized representative for the notice)~~ prior to the initiation of the change or reduction. The notice shall indicate the agreed upon effective date; and

~~4) rights of appeal shall not be denied to a participant/authorized representative who has requested a change or reduction in CCP services; and~~

4~~5~~) the CCU has documented all of the requirements of this subsection (b) and placed the participant's statement in the case record.

c) When an assessment or reassessment for services requires an increase, or no change in service, the participant/authorized representative and the provider shall be notified in writing. The notice shall be mailed or emailed~~by regular mail to the participant/authorized representative~~ within 15 calendar days after the date of the assessment or reassessment.

~~d) A copy of any notification mailed/hand-delivered to a participant/authorized representative shall be mailed/provided to the appropriate provider on the same date it is mailed/hand-delivered to the participant/authorized representative.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.950 Reasons for Termination

a) A participant shall be terminated from CCP for one~~1~~ or more of the reasons identified in this Section:

1~~a~~) participant is deceased;

2~~b~~) participant has been institutionalized or is otherwise not available for services for more than 60 calendar days;

3~~c~~) participant's condition has improved and there is no longer a need for CCP services as measured by the CCP DON to determine need for long-term services and supports;

4~~d~~) participant cannot be located;

5~~e~~) participant/authorized representative has requested termination of services;

6~~f~~) participant/authorized representative refuses transfer to a different provider~~vendor~~/CCU and the current provider~~vendor~~/CCU cannot provide services needed by the participant;

7~~g~~) participant/authorized representative has failed to cooperate with the Department/CCU/provider~~vendor~~ as required and as specified in Section 240.350;

8~~h~~) participant no longer meets citizenship requirements;

9~~i~~) participant no longer meets residency requirements;

10~~j~~) the CCU determines that an adequate person-centered plan of care cannot be developed that meets the participant's determined needs under Section 240.715.

11~~k~~) the total value of a participant's non-exempt assets has increased and exceeds $17,500;

4020
4021 12~~l~~) participant/authorized representative failed to report the transfer of non-
4022 exempt assets within the past 60 months for the purpose of obtaining CCP
4023 services;
4024
4025 13~~m~~) participant/authorized representative has failed to report or refused to
4026 provide documentation of changes in circumstances, as required by
4027 Section 240.360;
4028
4029 14~~n~~) participant/authorized representative refuses to sign a Participant
4030 Agreement – Person-centered Plan of Care;
4031
4032 15~~o~~) participant refuses to sign the Participant Agreement and Consent Form in
4033 accordance with Section 240.330;~~ or~~
4034
4035 16~~p~~) participant~~Participant~~/authorized representative refuses to apply for and, if
4036 eligible, enroll in medical assistance under Article V of the Public Aid
4037 Code, as required by Section 240.865;~~.~~
4038
4039 17) participant/authorized representative threatened violence or committed
4040 actual violence against a Department representative/CCU/provider as
4041 specified in Section 240.355; or
4042
4043 18) participant has been convicted of fraud or an OIG investigation has
4044 determined that fraud has occurred.
4045
4046 b) A participant cannot be terminated for attempting to exercise or exercising their
4047 right to appeal an action by the CCU or provider.
4048
4049 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
4050
4051 SUBPART J: SPECIAL SERVICES
4052
4053 **Section 240.1010 Choices for Care Pre and Post Screening and Informed Choice~~Nursing~~**
4054 **~~Facility, Supportive Living Program, and Community-Based Screening~~**
4055
4056 a) Choices for Care ~~nursing facility, supportive living program, and community-~~
4057 ~~based~~ prescreening is the determination~~assessment~~ of the need for institutional
4058 long term care services and/or other long term services and supported programs
4059 that require an institutional level of care, including the supportive living program
4060 settings. All~~of all~~ participants age 60 and over, regardless of the payment source,
4061 must be determined eligible prior to placement in a nursing facility (licensed
4062 under the Nursing Home Care Act; certified to participate in the Medicare

program under Title XVIII of the Social Security Act (42 U.S.C.~~USC~~ 301 et seq.), or certified to participate in the Medicaid program under Title XIX of the Social Security Act; placement in a supportive living program (Medicaid waiver)); or to determine if the participant/authorized representative chooses community-based services and supports.

b) Except as indicated in subsections (j) and (l), any participant seeking admission to a nursing facility or supportive living program must be screened to determine their level of care~~his/her~~ need for nursing facility or supportive living program services pursuant to this Section.

c) Prescreening includes the completion of the level of care to determine eligibility for institutional level of care or supported living program setting placement.~~shall be accomplished by completion of the DON, completion of the HFS Interagency Certification of Screening Results form, and completion of an HFS OBRA Level I Screen if the participant is determined appropriate for nursing facility or supportive living program placement.~~ In addition, the participant will receive copies~~a copy~~ of brochures related to the following subject matters:

1) Privacy Practices~~*Notice of Privacy Practices* brochure~~; and

2) Adult Protective Services~~*Your need to know about Adult Protective Services*~~ brochure.

d) In compliance with federal Preadmission Screening and Resident Review (PASRR) requirements, when CCUs completing the HFS ~~OBRA~~ Level I Screen for individuals residing in the community to determine if there is a suspicion of and a reasonable basis to suspect mental illness and/or developmental disability, the CCU shall make the appropriate referral to the state designed entity~~contracted providers of DHS-Division of Mental Health or DHS-Division of Developmental Disabilities~~ within one~~1~~ day to determine if an HFS ~~OBRA~~ Level II Screen is required. If it is determined that no further screening is required ~~by the DHS contracted providers~~, the CCU shall complete the required forms. If further screening is required by the state designated entity~~DHS contracted providers~~, that entity shall complete the required forms.

e) The hospital shall notify the CCU at least 24 hours prior to discharge.

f) CCUs will have the capacity to complete face-to-face prescreenings seven~~7~~ days per week, at a minimum of seven~~7~~ hours per day. ~~CCUs are not required to complete screens on federal holidays.~~

g) Responsibility for prescreenings shall be vested in the CCUs. The CCU is

responsible for ensuring that copies of the HFS Interagency Certification of Screening Results form and the HFS ~~OBRA~~ Level I Screen shall be submitted to the state designated entity within the required timeframe.~~are sent to the appropriate nursing facility or supportive living program.~~

h) The participant who is prescreened shall:

1) be afforded informed choice including an explanation of all support~~appropriate~~ options, including nursing facility, supportive living program setting, ~~in~~ home and community-based services; and

2) be advised of their~~his/her~~ right to refuse nursing facility, supportive living program setting, ~~in~~ home and~~,~~ community-based, or all services.

i) Postscreening shall occur if a participant is admitted to a nursing facility or supportive living program setting without benefit of prescreening.

1) Postscreening may occur for any of the following reasons:

A) after nursing facility or supportive living program setting placement in an emergency situation when there is a pre-existing condition of need for a caregiver and the caregiver is no longer able to provide care. The CCU shall conduct prescreening within two~~2~~ calendar days after the date of the request for postscreening;

B) for nursing facility or supportive living program admissions from a hospital emergency department~~room~~ or outpatient services; or

C) for nursing facility or supportive living program setting admissions for participants coming from out-of-state.

2) The CCU shall conduct a postscreening within two~~2~~ calendar days after the date of the request for postscreening.

j) Nursing facility prescreening does not apply to the following:

1) Transfers from one~~1~~ nursing facility to another.

2) Admissions to a continuing care retirement community with which the participant has a life care contract.

3) Participants who are receiving or will be receiving hospice services.

4149 4) Returns to a nursing facility from a hospital.
4150
4151 5) Admissions to a nursing facility from the community for respite care for a
4152 period of no more than 15 calendar days.
4153
4154 6) Admissions to sheltered care facilities.
4155
4156 7) Participants who resided in a nursing facility on June 30, 1996.
4157
4158 8) Participants who resided in a nursing facility for a period of at least 60
4159 calendar days who are returning to a nursing facility after an absence of
4160 not more than 60 calendar days.
4161
4162 k) A prescreening or postscreening for supportive living program setting admissions
4163 is not required for:
4164
4165 1) Hospice services;
4166
4167 2) Caregiver respite services;
4168
4169 3) Transfers from nursing facilities licensed under the Nursing Home Care
4170 Act and certified to participate in the Medicaid program or another
4171 supportive living program setting without a break in service. It is the
4172 admitting supportive living program setting'sprogram's responsibility to
4173 ensure that a screening document is received from the transferring nursing
4174 facility or supportive living program setting; or
4175
4176 4) Residents who were admitted to a supportive living program setting from
4177 a hospital to which they were transferred for the purpose of receiving care.
4178
4179 l) Any participant who has been admitted to a nursing facility that operates under
4180 the Hospital Licensing Act [210 ILCS 85], or provider licensed under Section 35
4181 of the Alternative Health Care Delivery Act [210 ILCS 3/35], whose actual length
4182 of stay in the facility exceeds 21 calendar days, shall be screened to determine the
4183 participant's need for continued services.
4184
4185 m) Nursing facility conversion screening is the assessment of the appropriateness of
4186 in-home and community-based care for nursing facility residents age 60 and over
4187 who have applied for and been found eligible for Medicaid assistance.
4188
4189 1) Conversion screens shall be initiated by a referral from HFS.
4190
4191 2) Conversion screens shall be accomplished in accordance with

Deinstitutionalization (see Section 240.1960(g)). A Deinstitutionalization assessment will be conducted within 60 days after the date of admittance to the nursing facility if the participant chooses to have follow-up by the CCU.

3) Conversion screens shall include the option of CCP transitional services for those participants who are appropriate for in-home and community-based services.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1020 Interim Services

Interim services are CCP services provided to participants age 60 and over on an interim basis, dependent upon the participant's presumptive eligibility and following prescreening of the participant.

a) Presumptive eligibility shall be based upon the following criteria:

1) A referral has been received from a participant age 60 or over, or from the participant's authorized representative, following prescreening.

2) Notification has been received by the CCU from a hospital or from a participant/authorized representative or agency in the community that the participant is at imminent risk of nursing facility placement within three~~3~~ calendar days.

3) The DON to determine need for long-term services and supports has been administered.

4) The participant/authorized representative has provided declared information on all other CCP eligibility requirements.

5) The participant/authorized representative has signed a Participant Agreement and Consent Form.

6) After presumptive eligibility has been determined, the CCU shall notify the provider~~vendor~~ within the next business day and services will start within two~~2~~ business days.

b) When presumptive eligibility has been determined and interim services are approved in accordance with the person-centered plan of care, services shall be initiated by the provider~~vendor~~ to the participant within two~~2~~ work days after the

date of notification to the provider~~vendor~~ of the participant's presumptive eligibility.

c) A comprehensive assessment shall be administered in the residence of the participant by the CCU.

1) When the assessment is not conducted in the community, the CCU will make the follow-up home visit within 15 calendar days after the date of the participant's discharge.

2) When the assessment is conducted in the community, the CCU will make the follow-up home visit within 30 calendar days after the date of the interim assessment.

3) The formal determination of eligibility for CCP services shall be completed within 90 calendar days after the date of receipt of the referral.

d) Interim services may continue up to a maximum of 90 calendar days after the date of referral, pending finalization of the formal determination of eligibility by the CCU. Services shall be denied at any time during the 90 calendar day interim service period:

1) if evidence of ineligibility, based upon any eligibility requirement, is determined;

2) if the participant/authorized representative fails to cooperate in the determination of eligibility process;

3) as specified in Section 240.660, in the event that a participant's eligibility cannot be determined due to the participant's/authorized representative's failure to provide accurate and verifiable documentation regarding eligibility within 90 calendar days after the date of receipt of the referral; or

4) if a person-centered plan of care cannot be developed that adequately meets the participant's determined needs (see Section 240.920(n)).

e) Notification of eligibility or ineligibility shall be provided in writing. If eligibility is denied, provision of interim services shall cease on the date of receipt by the provider~~vendor~~ of the Participant Agreement – Person-Centered Plan of Care.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1040 Intense Service Provision

Several CCP workers' services (not to exceed four~~4~~) may be utilized, on a one~~1~~-time basis only, to clean a new participant's home, thereby making it possible to maintain the health and safety of the participant. However, the total monthly service costs may not exceed the maximum monthly cost allowable as indicated on the participant agreement.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1050 Temporary Service Increase

A participant who is currently receiving services under CCP may request a temporary service increase when they~~he/she~~ is at imminent risk of nursing facility care or has been hospitalized for not more than 60 calendar days.

a) The CCU will conduct the DON to determine need for long-term services and supports within two~~2~~ calendar days after notification.

b) The CCU will assist the participant/authorized representative with the completion of the Participant Agreement and Consent Form. The CCU shall verbally authorize a temporary increase in services if the need is indicated by the determination. The CCU shall notify the provider~~vendor~~ by telephone to reinstate services, giving the date of discharge and the temporary increase.

c) Notification shall be given to the participant/authorized representative and the provider~~vendor~~ immediately following completion of the required forms. The notification shall be confirmed in writing. Both the verbal and written notification shall indicate the increase and the temporary nature of the increase.

d) The CCU shall make a home visit to the participant for the purpose of redetermination of need to determine if the temporary increase should be continued or reduced. (See Section 240.620(c).)

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

SUBPART K: TRANSFERS

Section 240.1110 Participant Transfer Request − Provider~~Vendor~~ to Provider~~Vendor~~ − No Change in Service

a) The Department, a CCU or a participant/authorized representative may request a transfer for provision of CCP services from one provider~~1 vendor~~ to another provider~~vendor~~, within the same service area, and without any change in service

needs. The transfer request may be initiated by verbally advising the CCU of the desired change in provider~~vendor~~. The CCU shall verbally advise the participant of the provider~~vendor~~ choices available. The CCU shall complete a new Participant Agreement and Consent Form – Person-Centered Plan of Care, including choice of vendor based upon that verbal advice from the participant/authorized representative as to their~~his/her~~ selection.

b) Reasons for the CCU to authorize a provider~~vendor~~ to provider~~vendor~~ transfer with no change in services provided may include:

1) the needs of a participant are not being met by the current provider~~vendor~~; or

2) the participant has exercised their~~his/her~~ right of freedom of choice and requested transfer.

c) Within five~~5~~ work days after the date of receipt of a verbal request to effect a transfer, the CCU shall forward a new Participant Agreement and Consent Form and new CCP Participant Agreement to the participant/authorized representative for signature.

d) Within 30 calendar days after the date of receipt of the signed Participant Agreement and Consent Form:

1) the CCU shall:

A) complete a person-centered plan of care establishing the effective date of transfer; and

B) forward:

i) the person-centered plan of care to the participant/authorized representative;

ii) a copy of the Participant Agreement − Person-Centered Plan of Care to the receiving provider~~vendor~~ on the same day the Participant Agreement − Person-Centered Plan of Care is sent to the participant; and

iii) a copy of the Participant Agreement − Person-Centered Plan of Care to transferring provider~~vendor~~.

2) upon receipt of the provider's~~vendor's~~ signature on the Participant

4364 Agreement – Plan of Care, the CCU shall place a copy of the executed
4365 Participant Agreement – Plan of Care in the CCU's participant file and a
4366 copy shall be forwarded to the participant/authorized representative.
4367
4368 e) The effective date of the transfer shall be within 15 calendar days after the date of
4369 the Participant Agreement − Person-Centered Plan of Care and service shall be
4370 initiated by the receiving providervendor without service interruption.
4371
4372 f) If a delay in any of the time frames established in this Section is caused by the
4373 documented action or inaction of the participant/authorized representative, time
4374 frames shall be extended by the number of calendar days of the delay.
4375
4376 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
4377
4378 **Section 240.1120 Participant Transfer Request – ProviderVendor to ProviderVendor –**
4379 **With Change in Service**
4380
4381 a) A request for transfer of a CCP participant from one provider1 vendor to another
4382 providervendor within the same service area that requires a change in the services
4383 provided shall be completed by the CCU following a redetermination of need.
4384 The request may be initiated by the Department, CCU, the vendor, or the
4385 participant/authorized representative verbally or in writing to the CCU. The CCU
4386 shall complete the redetermination of need, including obtaining a completed and
4387 signed Participant Agreement and Consent Form – Person-Centered Plan of Care
4388 from the participant/authorized representative, within 30 calendar days after the
4389 date of the request unless delayed by the participant/authorized representative.
4390
4391 b) Reasons for a providervendor to providervendor transfer with a required change
4392 in service may include:
4393
4394 1) a change in the participant's condition; and
4395
4396 2) the provider'svendor's inability to meet the service needs of the participant,
4397 as required by the person-centered plan of care.
4398
4399 c) The CCU shall:
4400
4401 1) no later than 15 calendar days after the date of redetermination, complete
4402 in accordance with Section 240.945 and forward:
4403
4404 A) the Participant Agreement − Person-Centered Plan of Care to the
4405 participant/authorized representative;
4406

B) a copy of the Participant Agreement − Person-Centered Plan of Care, the CCP Participant Agreement to the receiving provider~~vendor~~ on the same day the Participant Agreement − Person-Centered Plan of Care is sent to the participant/authorized representative;

C) a copy of the Participant Agreement − Person-Centered Plan of Care to the transferring provider~~vendor~~.

2) Upon receipt of the provider's~~vendor's~~ signature on the Participant Agreement – Person-centered Plan of Care, a copy of the executed Participant Agreement – Person-centered Plan of Care shall be placed in CCU's participant file and a copy shall be forwarded to the participant/authorized representative.

d) The effective date of transfer shall be no later than 15 calendar days after the date of the Participant Agreement − Person-Centered Plan of Care and service shall be initiated by the receiving provider~~vendor~~ without service interruption.

e) If any delay in any of the time frames established in this Section is caused by the documented action or inaction of the participant/authorized representative, time frames shall be extended by the number of calendar days of delay.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1130 Participant Transfers – Care Coordination Unit to Care Coordination Unit

a) A CCP participant may transfer from one~~1~~ CCU service area to another CCU service area with continuous eligibility pending a redetermination of eligibility by the receiving CCU. The transfer may be requested by the Department, a CCU, or the participant/authorized representative verbally or in writing.

b) A reason for transfer from CCU to CCU shall be a geographic change in the participant's residence.

c) The effective date of transfer shall be within 15 calendar days after the date of the Participant Agreement − Person-Centered Plan of Care and services shall be initiated by the receiving provider~~vendor~~ without service interruption.

d) To implement the transfer, the transferring CCU, within five~~5~~ work days after the date of a request or notice of need to transfer, or five~~5~~ work days prior to the effective date of transfer, whichever provides the most notification to the

receiving CCU, shall:

1) notify the receiving CCU of the impending transfer and the desired date of transfer;

2) forward to the receiving CCU the original case record of the transferring participant; and

3) forward the Participant Agreement − Person-Centered Plan of Care to the participant/authorized representative and a copy to the transferring provider~~vendor~~.

e) The receiving CCU shall:

1) Upon receipt of the participant's case record, advise the participant/authorized representative as to the providers~~vendors~~ in the CCU's area that are authorized, and appropriate, to provide the participant's service needs in accordance with the participant's person-centered plan of care. The participant shall advise the CCU as to their~~his/her~~ selection and the CCU shall complete a new Participant Agreement and Consent Form − Person-Centered Plan of Care.

2) Forward to the participant/authorized representative a new completed Participant Agreement and Consent Form – Person-Centered Plan of Care for signature.

3) Upon receipt of the signed Participant Agreement and Consent Form – Person-Centered Plan of Care, establishing the effective date of the transfer.

4) Forward:

A) the Participant Agreement − Person-Centered Plan of Care to the participant/authorized representative;

B) a copy of the Participant Agreement − Person-Centered Plan of Care and the old Participant Agreement – Person-Centered Plan of Care and a copy of the applicable pages of the comprehensive assessment to the receiving provider~~vendor~~ on the same day the Participant Agreement − Person-Centered Plan of Care is sent to the participant/authorized representative.

5) Upon receipt of the provider's~~vendor's~~ signature on the new Participant

4493 Agreement – Person-Centered Plan of Care, a copy of the executed
4494 Participant Agreement – Person-Centered Plan of Care is to be placed in
4495 CCU's participant file and a copy shall be forwarded to the
4496 participant/authorized representative.
4497
4498 f) If any delay in any of the time frames established by this Section is caused by the
4499 documented action or inaction of the participant/authorized representative, time
4500 frames shall be extended by the number of days of delay.
4501
4502 g) The receiving CCU shall perform an initial determination of eligibility of the
4503 participant and develop a new person-centered plan of care within 30 calendar
4504 days after the date of receipt of the case record.
4505
4506 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
4507
4508 **Section 240.1160 Temporary Transfers – Care Coordination Unit to Care Coordination**
4509 **Unit**
4510
4511 a) A CCP participant/authorized representative may request a transfer from the
4512 participant's CCU service area to another CCU service area for a temporary period
4513 of time, not to exceed 31 calendar days, when the participant is temporarily
4514 residing with a relative, or other responsible individual, but intends to return to
4515 the participant's permanent residence. When the temporary transfer exceeds 31
4516 calendar days, the transfer is considered to be permanent (see Section 240.1130).
4517
4518 b) The managing CCU shall retain primary responsibility for the participant and
4519 maintenance of the participant's original records.
4520
4521 c) To implement the temporary transfer, the managing CCU, within five~~5~~ work days
4522 after the date of request or notice of need to transfer, shall:
4523
4524 1) notify the temporary CCU of the impending transfer, the participant's
4525 name, temporary address and telephone number, the anticipated length of
4526 stay and the type and amount of CCP service to be provided, and whether
4527 the participant has an authorized representative;
4528
4529 2) obtain from the temporary CCU, and provide to the participant/authorized
4530 representative, a list of authorized and appropriate providers~~vendors~~ in the
4531 temporary CCU's service area;
4532
4533 3) complete a Participant Agreement and Consent Form and obtain
4534 signatures from the participant/authorized representative;
4535

4) complete a new Participant Agreement – Person-Centered Plan of Care, obtain signatures and forward copies as appropriate;

5) provide the temporary CCU with a copy of the Case Documentation for Determination of Need;

6) prepare and forward a Participant Agreement − Person-centered Plan of Care;

7) authorize the temporary provider~~vendor~~ to receive payment for CCP services provided, beginning on the effective service date;

8) provide the temporary provider~~vendor~~ with information required for billing for CCP services provided to the participant.

d) The temporary provider~~vendor~~ shall advise the temporary CCU of any needed adjustments in the participant's person-centered plan of care.

e) The temporary CCU shall:

1) if advised by the temporary provider~~vendor~~, make a home visit to the participant and identify possible needed changes;

2) advise the managing CCU and the temporary provider~~vendor~~ of any changes needed in the participant's person-centered plan of care;

3) monitor the provision of services to the participant;

4) advise the managing CCU of the date of the participant's expected return to a~~his/her~~ permanent residence.

f) The participant/authorized representative shall advise the temporary CCU of the date of the participant's expected return to their~~his/her~~ permanent residence no later than five~~5~~ work days prior to the date of the participant's return.

g) Upon the participant's return to their~~his/her~~ permanent residence, the managing CCU shall:

1) terminate the authorization of the temporary provider~~vendor~~ to receive payment for CCP services provided to the participant;

2) reinstate authorization for the permanent provider~~vendor~~ to receive payment for CCP services provided to the participant;

3) notify the permanent provider~~vendor~~ of the reinstatement and the first day that services shall be provided to the participant by the permanent vendor;

4) prepare and forward a Participant Agreement − Person-Centered Plan of Care.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1170 Caseload Transfer – Provider~~Vendor~~ to Provider~~Vendor~~

a) A caseload transfer shall occur when the serving provider's~~vendor's~~ contract for provision of CCP services has been terminated by either party to the contract.

b) The Department shall notify the appropriate CCU of the impending transfer and the effective termination date, and forward a copy of each notification to the respective transferring and receiving providers~~vendors~~.

c) The participant/authorized representative shall complete the Participant Agreement and Consent Form and forward it to the CCU by the date specified in the Department notice (no later than 15 calendar days after the date of mailing by the Department).

d) Within five~~5~~ work days after the date specified by the Department in subsection (c), the CCU shall identify the receiving provider~~vendor~~ for each participant in the caseload, using the completed Participant Agreement and Consent Form or the approved rotation plan, if a Participant Agreement and Consent Form has not been received.

e) Upon adequate notification by the Department of the provider's~~vendor's~~ intent to terminate its contract, the CCU shall:

1) advise the receiving provider~~vendor~~ verbally of the impending transfer of the participants and the date that service must be initiated for each participant to prevent interruption of service;

2) send written notification to the participants/authorized representatives giving the date of initiation of service by the receiving provider~~vendor~~; and

3) send a new Participant Agreement – Person-Centered Plan of Care and applicable pages of the comprehensive assessment for each transferring participant to the appropriate receiving provider~~vendor~~.

4622
4623 f) The time frame specified in subsection (e) does not apply when an emergency
4624 procurement action is required due to contract termination and to prevent
4625 interruption of participant services.
4626
4627 g) The participant's/authorized representative's signature shall be obtained on the
4628 new Participant Agreement – Person-Centered Plan of Care and copies distributed
4629 as appropriate.
4630
4631 h) The transfer of a caseload must be completed no later than the effective
4632 termination date of the contract.
4633
4634 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
4635
4636 SUBPART M: CARE COORDINATION UNITS AND PROVIDERS
4637
4638 **Section 240.1310 Standard Contractual Requirements for Care Coordination Units and**
4639 **Providers**
4640
4641 a) The contract shall be an agreement between the Department and the CCU or
4642 provider agency as evidence of the terms and conditions of the contract. The
4643 terms and conditions shall, at a minimum, include the following:
4644
4645 1) the contractual agreement between the Department and the CCU/provider
4646 may be terminated without cause by either party upon 60 calendar days
4647 written notice;
4648
4649 2) the contractual agreement between the Department and the CCU/provider
4650 may be amended, with the mutual consent of both parties, at any time
4651 during the term of the contract; and
4652
4653 3) all program and financial records, reports, and related information and
4654 documentation, including participant files, that are generated as a result of
4655 the agreement shall be considered the property of the Department.
4656
4657 b) Upon written notification from the Department of a change in the fixed unit rates
4658 of reimbursement, the CCU/provider may exercise its 60 calendar day termination
4659 rights if the CCU/provider no longer wishes to provide service at the newly
4660 established fixed unit rates of reimbursement.
4661
4662 c) CCUs and providers shall have sufficient personnel to ensure service to all CCP
4663 participants.
4664

4665 d) At the time of application for award of contracts, CCUs and providers shall
4666 submit documentation specified by the Department to confirm the legal structure
4667 under which they are doing business.
4668
4669 e) CCUs and providers may be units of State government, units of local government,
4670 for-profit or not-for-profit corporations, limited liability companies, sole
4671 proprietorships, partnerships or individuals.
4672
4673 1) An agency of State government must submit a letter from the Director or
4674 head of the agency citing the statutory authority for the agency to enter
4675 into a contract to provide the proposed CCP service.
4676
4677 2) A unit of local government must submit a copy of the resolution or
4678 ordinance duly passed by the governing body of the unit of government
4679 authorizing the execution of the contract. The resolution or ordinance
4680 shall designate the individual authorized to execute the agreement in
4681 behalf of that unit of government.
4682
4683 3) A partnership, individual or sole proprietorship must submit copies of
4684 "Certificate of Ownership of Business" issued by the County Clerks for
4685 the counties in which the applicant agency is proposing to provide service.
4686
4687 4) A corporation or limited liability company must submit a "Certificate of
4688 Good Standing" from the Office of the Illinois Secretary of State
4689 certifying that the corporation has complied with the requirement to file an
4690 annual report and has paid required franchise taxes.
4691
4692 5) A not-for-profit corporation shall submit:
4693
4694 A) a "Certificate of Good Standing" from the Office of the Illinois
4695 Secretary of State certifying that the corporation has complied with
4696 the requirement to file an annual report; and
4697
4698 B) a current letter from the Office of the Illinois Attorney General
4699 certifying that the corporation is in full compliance with or is
4700 exempt from the charitable trust laws of the State of Illinois.
4701 Thereafter, a non-exempt provider shall provide a letter, certified
4702 by the provider's Board of Directors, to the Department upon
4703 request, stating that the provider remains in compliance or is
4704 exempt.
4705
4706 6) A nongovernmental agency shall certify that:
4707

A) CCU/provider or any of its officers, agents or employees have not been convicted of bribery or attempting to bribe an officer or employee of the State of Illinois nor made an admission of guilt of such conduct which is a matter of record; and

B) CCU/provider is not in arrears or not in default to the State of Illinois upon any debt or contract, and that it is not in default as to the surety, or otherwise, upon any obligation to the State of Illinois, and that it has not failed to perform faithfully any previous contract with the State of Illinois.

f) CCUs and providers shall certify that their respective agency acknowledges and complies with the Illinois Human Rights Act [755 ILCS 5]; the Equal Employment Opportunity Act of 1974, as amended (Title VII of the U.S. Civil Rights Act of 1964, as amended (42 U.S.C.~~USC~~ 2000e et seq.)); the Civil Rights Act of 1964, as amended (42 U.S.C.~~USC~~ 2000d et seq.); section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C.~~USC~~ 790 et seq.); and the Immigration Reform and Control Act of 1986 (8 U.S.C.~~USC~~ 1101 et seq.).

g) CCUs and providers shall certify to the Department that their respective agencies are fiscally sound, as defined in Section 240.160, or demonstrate the ability to obtain financial resources as required during the performance of their contract.

h) Assignment by a CCU or provider of a contract awarded between the CCU or provider and the Department to any other organizations or entities shall result in the immediate termination of the CCU or provider contractual agreement.

i) Failure by CCUs or providers to seek and obtain written Department approval prior to entering into subcontracts with other entities for the provision of CCPCCP services shall result in the immediate termination of the CCU or provider contractual agreement.

j) The Department shall be immediately notified in the event of a merger/consolidation/sale of assets of a CCU or provider by the CCU or provider and provided with copies of all relevant supporting documents.

1) Following review of the merger/consolidation/sale of assets documents by General Counsel, the Department will determine whether the merger/consolidation/sale of assets has resulted in an assignment of the contract (see subsection (h)).

2) If the merger/consolidation/sale of assets has not resulted in an assignment, the Department retains the right to terminate the contract if

4751 performance of the contract by the new corporate structure is not in the
4752 best interests of the CCP, such as a merger or consolidation with an entity
4753 that has been subject to previous contract action by the Department or
4754 some other state or federal agency.
4755
4756 3) Failure to notify the Department shall result in termination of the CCU or
4757 provider contract.
4758
4759 k) The CCU/provider must notify the Department and receive approval before
4760 initiating any pilot program involving participants. Failure to receive approval
4761 may result in contract action.
4762
4763 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
4764
4765 **Section 240.1320 ProviderVendor or Care Coordination Unit Fraud/Illegal or Criminal**
4766 **Acts**
4767
4768 a) Reporting of Illegal Acts
4769
4770 1) Any entity involved in the administration of the CCP or in the provision of
4771 CCP services, upon receipt of any report of or evidence of an improper or
4772 unlawful act having been committed by their employees, for the purpose
4773 of illegally obtaining money or extorting payment for care, goods, services
4774 or supplies, shall immediately:
4775
4776 A) inform the appropriate law enforcement authorities; and
4777
4778 B) report to the Department, including any documentation which may
4779 have been obtained, regarding any alleged theft or missing items
4780 having value over $50.00 or such unlawful activities which result
4781 in a police report.
4782
4783 2) Failure of a CCU or providervendor to make a report to the appropriate
4784 law enforcement authorities and to the Department shall result in contract
4785 action as delineated in Section 240.1665 for vendors and Subpart N for
4786 CCUs.
4787
4788 b) Department staff, designated by the Director, shall make an immediate
4789 investigation of the alleged improper or unlawful acts. When the result of the
4790 Department's investigations produces evidence that indicates
4791 CCU/providervendor improprieties or unlawful activities, the Department shall
4792 make an immediate report to the appropriate law enforcement authorities.
4793

c) Any entity or individual provider involved in the administration/provision of CCP services shall not bill the Department for more services than were provided to or on behalf of CCP participants.

1) Anyone in receipt of information that the Department has been improperly billed for services shall report the incident to the Department and provide the Department with any report/documentation that may have been obtained.

2) Department staff, designated by the Director, shall complete an immediate review of the report.

3) If the Department determines that the allegations in the report are factual, based upon the above cited-review, the Department will advise the CCU or provider~~vendor~~ in writing regarding what action shall be taken (e.g., no action, if in the best interests of the participant; suspension; termination). ~~(See Sections 240.1399 and 240.1665 for vendors and Subpart N for CCUs.)~~

d) Any entity or individual involved in the provision of CCP services shall cooperate with and provide assistance to the Department/law enforcement authorities in any investigation of any alleged illegal or criminal act. ~~(See Section 240.1665 for vendors and Subpart N for CCUs.)~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1399 Termination of a Provider~~Vendor~~ or Care Coordination Unit (CCU)

In the event conditions warrant termination of an Agreement or a Contract, termination shall be in accord with provisions in the Agreement or Contract.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

SUBPART N: CARE COORDINATION UNITS

Section 240.1400 Community Care Program Care Coordination

a) A designated CCU, as outlined in 89 Ill. Adm. Code 220.600 through 220.675, shall be contracted with as a CCU by the Department for a specific geographic area by executing a contract for the provision of CCP care coordination services.

b) All providers of CCP care coordination services shall meet all standards promulgated by the Department relating to the services provided, upon

completion of the procurement.~~ as specified in 89 Ill. Adm. Code 220.610 through 220.675~~ All Department funded CCUs must adhere to the equal opportunity requirements of the Illinois Department of Human Rights and the contract executed between the CCU and the Department.

c) Care coordination services shall be purchased only from providers determined capable and competent by the Department to provide those services,~~ as described in 89 Ill. Adm. Code 220.600 through 220.675~~ once a procurement has occurred ~~under 89 Ill. Adm. Code 220.610 through 220.675~~.

d) CCU contracts with the Department to provide CCP care coordination services shall not be assigned.

e) CCUs shall not subcontract for the direct provision of CCP care coordination services unless prior written approval has been obtained from the Department.

f) A CCP provider may not serve as a CCU in the same contract service area except temporarily to provide for the orderly transition of duties while the Department seeks a replacement CCU or the Department seeks a replacement provider, as indicated in the particular case. In no instance shall that arrangement exist for longer than a three~~3~~ month period.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1410 Care Coordination Unit Administrative Minimum Standards

a) A CCU must meet the Standard Contractual Requirements of Section 240.1310.

b) A CCU shall be open for business at least seven~~7~~ hours each weekday (Monday through Friday) and shall have and utilize an alternative method approved by the Department, and on file at the CCU, for receiving requests from participants on any weekdays (excluding holidays) when the CCU is not open for business.

c) All program records, reports, and related information and documentation, including participant files, that are generated in support of the contract between the CCU and the Department shall be considered the property of the Department.

1) The CCU shall submit, upon demand, or otherwise make available at the option of the Department, all such records, information and documentation to the Department/Department authorized designee.

2) All the records, information and documentation shall be maintained by the CCU in accordance with provisions of 89 Ill. Adm. Code 220.100.

3) All records, case notes or other information maintained on persons served under the contract shall be confidential and shall be protected by the CCU from unauthorized disclosure as required by 89 Ill. Adm. Code 220.100 and Section 240.340 of this Part.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1420 Care Coordination Unit Responsibilities

CCUs, in the performance of their CCP contract, shall have the following responsibilities for purposes of care coordination:

a) Intake~~intake~~ to address public inquiries regarding services and supports and making preliminary decisions regarding need for a home visit for a comprehensive assessment.

b) Determine functional and financial eligibility for services, including:

1) scheduling a face-to-face meeting between a certified Care Coordinator and a participant/authorized representative;

2) utilizing the comprehensive assessment tool, or any successor assessment tool used to determine need for long-term services and supports authorized by the Department, including all addenda, to assess the participant's functional needs, cognitive, psychological, and social well-being, including but not limited to participant demographics, physical health history and assessment, behavioral health, medications, nutritional screening, caregiver, transportation, environment, financial, legal status, and person-centered goals of care, as well as other factors contributing to quality of life and the ability to live independently in the community;

3) reporting alleged or suspected abuse, neglect, financial exploitation, or self-neglect; assisting with investigations conducted under the Adult Protective Services Program; and making referrals to the State/Regional Long Term Care Ombudsman Programs.

4) identifying existing informal and formal support systems and the need for further evaluation by other disciplines, and/or services that would assist the participant in maintaining independent living and coordinating available resources to assist the participant/authorized representative to gain access to and receive needed services and supports, whether paid or unpaid, that will assist the participant to achieve identified goals, including

4923 distributing and assisting with completion of applications and forms
4924 required to access services identified in the goals of care; and
4925
4926 5) maintaining relationships with DHS, HFS, managed care entities,
4927 physicians, hospital discharge personnel, and providersproviders/vendors
4928 for the purpose of receiving input that may be beneficial to the CCU in
4929 exercising these responsibilities.
4930
4931 c) Fullfull responsibility for the performance of CCP
4932 determinations/redeterminations of eligibility, including residents of nursing
4933 homes seeking to return to the community, and development of a Participant
4934 Agreement – Person-Centered Plan of Care for each CCP client. (The Participant
4935 Agreement – Person-Centered Plan of Care can be revised only by the CCU.)
4936 CCUs should maintain liaison with DHS, HFS, physicians, hospital discharge
4937 personnel, and providers/vendors for the purpose of receiving input that may be
4938 beneficial to the CCU in exercising these responsibilities.
4939
4940 d) Developdevelop a Participant Agreement − Person-Centered Plan of Care for each
4941 participant receiving CCP services based on person-centered planning and
4942 freedom of choice in the selection of services, supports and providersvendors.
4943
4944 e) Monitormonitor the person-centered plan of care, including the Goals of Care, to
4945 ensure that services/resources are being provided.
4946
4947 f) Implementimplement transfer of a participant as required by Sections 240.1110
4948 through 1180.
4949
4950 g) Sendsend/hand deliver a person-centered plan of care to the participant/authorized
4951 representative as required by Sections 240.910 and 240.945. Also send/hand-
4952 deliver to providers/vendors, on same day the CCU sends the form to the
4953 participant/authorized representative, the following:
4954
4955 1) the applicable sections of the comprehensive assessment tool; and
4956
4957 2) copy of the Participant Agreement − Person-Centered Plan of Care.
4958
4959 h) Duringduring the face-to-face/in-person visit and, upon subsequent request,
4960 advise participants/authorized representatives of all rights and responsibilities
4961 under the CCP and furnish each participant/authorized representative with a copy
4962 of those rights and responsibilities, including a copy of "Things You Need to
4963 Know" brochures and Home Care Participant Bill of Rights brochures. Also
4964 provide a copy of the Request for Appeal form as promulgated by the Department
4965 and rendering assistance in filing the Request for Appeal form as requested or

4966 needed.
4967
4968 i) Arrangearrange for the implementation of CCP services by CCP providersvendors
4969 in accordance with the person-centered – plan of care, and develop memoranda of
4970 understanding when needed to maintain service. (See Section 240.350.)
4971
4972 j) Submitsubmit to HFS all requested records for issues under the Medical
4973 Assistance Program, and any other information or records for HFS to discharge its
4974 responsibilities as the Single State Agency under Title XIX of the Social Security
4975 Act.
4976
4977 k) Sendsend notification to the participant/authorized representative as required by
4978 Section 240.910 if a participant is determined ineligible for CCP services and
4979 providing linkage to other indicated services (e.g., Older Americans Act (42
4980 U.S.C.USC 3001 et seq.) services).
4981
4982 l) advise the participant/authorized representative of his/her right to receive a
4983 penalty payment as specified in Section 240.940 if the notice of eligibility is not
4984 mailed within 45 calendar days after the date on which a completed request is
4985 received by the Department or CCU.
4986
4987 lm) Informinform and assist the participant in the exercise of his/her rights to obtain
4988 an alternative provider as specified in Section 240.270 if provision of CCP service
4989 is delayed beyond the required time frame.
4990
4991 mn) Maintainmaintain a record of all participants receiving services under the CCP
4992 being served within the CCU's jurisdiction.
4993
4994 no) Addressaddress any request by participant/authorized
4995 representative/providervendor relating to CCP services and respond verbally/in
4996 writing within 15 calendar days after the date of request and so document in the
4997 participant's file.
4998
4999 op) Documentdocument in the participant's file all contact, verbal or written, with or
5000 on behalf of participants/authorized representatives.
5001
5002 pq) Monitormonitor for critical event notifications coming from Adult Protective
5003 Services, Emergency Home Response, In-Home and Adult Day Service providers.
5004 CCUs will respond to all critical event notifications by providing mandatory
5005 follow-up with CCP participants who have experienced a critical event. All
5006 critical event reports will be closed to reflect mandatory follow-up with CCP
5007 participants within 60 days after the date the event occurred or was identified to
5008 have occurred. CCUs will close critical event reports through completion of the

5009 60-day review summary housed in the Department's automated reporting system.
5010
5011 q~~r~~) Complete~~complete~~ and submit CCP assessment billing data to the Department;
5012 review and correct rejects; and provide assistance to providers~~vendors~~ with billing
5013 errors.
5014
5015 r~~s~~) Provide~~provide~~, in a timely manner, copies of all participant documents requested
5016 by the Department for participant appeals or other Departmental matters.
5017
5018 s~~t~~) Attend~~attend~~ hearings on appeals affecting participants under the CCU's
5019 jurisdiction and testify as requested. The CCU shall make available the
5020 appellant's case records at the hearing.
5021
5022 t~~u~~) Complete~~conduct~~ Choices for Care pre and post screening requirement within the
5023 required time frames and provide informed choice to participate~~prescreening,~~
5024 ~~postscreening, and Deinstitutionalization~~ in accordance with Section 240.1010.
5025
5026 u~~v~~) Comply with deinstitutionalization requirement as outlined in Section
5027 240.1010.~~conduct HFS OBRA-1 (Level I ID Screen).~~
5028
5029 v~~w~~) Provide~~provide~~ the Department with an annual financial audit report completed in
5030 accordance with Generally Accepted Audit Standards and Audit Guidelines
5031 issued by the Department.
5032
5033 1) The financial audit report shall be filed within six~~6~~ months after the close
5034 of the CCU's business fiscal year. The annual financial audit report must
5035 include, at a minimum, an income and expense statement and a balance
5036 sheet with the auditor's opinion and findings.
5037
5038 2) The annual financial audit report shall be filed with the~~ Illinois~~
5039 Department at its main office in Springfield.
5040
5041 w~~x~~) Maintain~~maintain~~ all records and documentation as specified in this Part and
5042 applicable procedures.
5043
5044 x~~y~~) Respond~~respond~~ to correspondence as required in performing all specified
5045 responsibilities.
5046
5047 y~~z~~) Obtain~~obtain~~ any necessary consent and cooperation for release of information
5048 when required to document case record material and to take subsequent indicated
5049 action.
5050
5051 z~~aa~~) Develop~~develop~~ and maintain resource listings for the geographic area served by

5052 the CCU, which will be shared with the Department upon request, to ensure that
5053 choices are presented to participants/authorized representatives in an objective
5054 manner that also allows for a rotation system for referrals to providers/vendors
5055 when the participant/authorized representative elects not to make a choice.
5056
5057 aabb) Performperform other activities as required by State or federal or local rules,
5058 regulations and ordinances as they relate to the CCP.
5059
5060 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
5061
5062 **Section 240.1430 Care Coordinator Staff Positions, Qualifications and Responsibilities**
5063
5064 a) A CCU shall have specified staff to carry out the following functions:
5065
5066 1) care coordination; and
5067
5068 2) supervision of care coordinators.
5069
5070 b) Care coordination supervisor qualifications shall be as specified in 89 Ill. Adm.
5071 Code 220.605(a)(2).
5072
5073 c) Care coordination qualifications shall be as specified in 89 Ill. Adm. Code
5074 220.605(b)(2).
5075
5076 d) Care coordinator activities and responsibilities shall, at a minimum, include:
5077
5078 1) administration of the DON;
5079
5080 2) development of a Participant Agreement – Person-Centered Plan of Care;
5081
5082 3) performance and/or approval of Choices for Care screening;
5083
5084 4) performance of HFS OBRA 1 (Level I ID Screen);
5085
5086 5) authorization of CCP services; and
5087
5088 6) attendance at appeal hearings.
5089
5090 e) Required activities that may be performed by a care coordinator or other CCU
5091 staff include:
5092
5093 1) screening of inquiries;
5094

2) arranging for service implementation in accordance with each specific Participant Agreement – Person-Centered Plan of Care;

3) completing required billing activities with the Department;

4) reviewing and correcting required billing activities with the Department;

5) assisting providers with Vendor Request for Payment (VRFP) rejects;

6) timely provision of documents requested by the Department for participant appeals or other Departmental matters;

7) implementing case transfers; and

8) assisting with completion and submission of participant Medicaid applications.~~referral of participants to HFS for Medicaid application as requested.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1440 Training Requirements For Care Coordination Supervisors and Case Coordinators

CCUs in the performance of their CCP contracts, shall adhere to the following training requirements~~ immediately upon adoption of this Section regardless of whether a procurement has occurred pursuant to 89 Ill. Adm. Code 220.610 through 220.675~~.

a) Care Coordinator (CC) Certification and Recertification~~Coordination Supervisors~~

1) Prior to performing CCP eligibility determinations and developing person centered plans of care, each care coordinator and each supervisor acting as a care coordinator shall successfully complete Department sponsored training on the CCP training comprehensive assessment tool, care planning, dementia training, and Choices for Care screening.~~Either prior to or within 60 calendar days after the date of employment with the CCU, each care coordination supervisor shall successfully complete:~~

~~A) Department sponsored CCP training on the DON eligibility determination, care planning, Choices for Care screening, and OBRA-1 (Level I ID Screen).~~

~~B) Successful completion of this training shall be established by certification.~~

2) Successful completion of this training shall be established by certification.~~Each care coordination supervisor shall meet the following in-service training requirements:~~

~~A) Recertification of CCP training within the 18 month anniversary of each previous recertification (e.g., recertification in September, subsequent recertification no later than March of the second following year);~~

~~B) 18 hours of documented in-service training on aging related subjects within each calendar year. For partial years of employment, training shall be prorated to equal 1.5 hours for each full month of employment. Documented participation in in-house staff training and/or local, State, regional or national conferences on aging related subjects, and the recertification required in subsection (a)(2)(A), will qualify as in-service training on an hour-for-hour basis.~~

3) Recertification of CCP training must be completed within the 18 months anniversary of each previous certification.

b) In-Services Training Requirements~~Care Coordinators~~

1) Annually, each care coordinator supervisor and care coordinator shall compete 20 hours of documented in-service training on aging related subjects. 2 of those hours shall be dementia training which shall include subjects related to Alzheimer's Dementia and Related Disorders; Safety Risks; and Communication and Behavior.~~Prior to performing CCP eligibility determinations and developing person-centered plans of care, each case manager and each supervisor acting as a care coordinator shall successfully complete:~~

~~A) Department sponsored CCP training on the DON, eligibility determination, care planning, Choices for Care screening and OBRA-1 (Level I ID Screen).~~

~~B) Successful completion of this training shall be established by preliminary certification which shall expire 6 months from completion of training.~~

2) For partial years of employment, training shall be prorated to equal 1.5 hours for each full month of employment. Documented participation in

5181 in-house staff training and/or local, State, regional or national conferences
5182 on aging related subjects will qualify as in-service training on an hour-for-
5183 hour basis. Recertification hours will not qualify for successful completion
5184 of this training. Completion of this training shall be established by
5185 certification.~~Each care coordinator and each supervisor acting as a care~~
5186 ~~coordinator manager shall meet the following training requirements:~~
5187
5188 c) All CCU employees not in receipt of Department training certificates must
5189 complete two hours of dementia training within 30 days of their employment and
5190 every calendar year thereafter. This training must include the following subjects:
5191 Alzheimer's Dementia and Related Disorders; Safety Risks; and Communication
5192 and Behavior.
5193
5194 ~~A) certification of CCP training within 6 months from the preliminary~~
5195 ~~certification (e.g., preliminary training in January, full certification~~
5196 ~~no later than July); and~~
5197
5198 ~~B) recertification of CCP training within the 18 month anniversary of~~
5199 ~~each previous certification (e.g., full certification in April,~~
5200 ~~subsequent recertification no later than October of the second~~
5201 ~~following year); and~~
5202
5203 ~~C) 18 hours of documented in-service training on aging related~~
5204 ~~subjects within each calendar year. For partial years of~~
5205 ~~employment, training shall be prorated to equal 1.5 hours for each~~
5206 ~~full month of employment. Documented participation in in-house~~
5207 ~~staff training and/or local, State, regional or national conferences~~
5208 ~~on aging related subjects, in addition to the certification required in~~
5209 ~~subsection (b)(2)(A), will qualify as in-service training on an hour-~~
5210 ~~for-hour basis.~~
5211
5212 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
5213
5214 SUBPART O: PROVIDERS
5215
5216 **Section 240.1505 Administrative Requirements for Certification**
5217
5218 a) In order to qualify for certification as a provider of CCP services, a provider
5219 agency must, to the satisfaction of the Department, meet the following
5220 administrative requirements:
5221
5222 1) Serve an entire CCP geographic area.
5223

5224 A) Other than in Cook County, the geographic area will be the county.
5225
5226 B) In Cook County outside the City of Chicago, the geographic area
5227 will be the township.
5228
5229 C) Within the City of Chicago, the geographic area will be the
5230 following subareas, defined by Zip Code:
5231
5232 i) 60626, 60640, 60645, 60659, 60660
5233
5234 ii) 60625, 60630, 60631, 60646, 60656
5235
5236 iii) 60634, 60639, 60641
5237
5238 iv) 60613, 60614, 60618, 60647, 60657
5239
5240 v) 60601, 60602, 60603, 60604, 60605, 60606, 60607, 60610,
5241 60611, 60622, 60642, 60654, 60661
5242
5243 vi) 60615, 60616, 60637, 60649, 60653
5244
5245 vii) 60609, 60623, 60629, 60632, 60638
5246
5247 viii) 60619
5248
5249 ix) 60620, 60621, 60636, 60643, 60652, 60655
5250
5251 x) 60608, 60612, 60624, 60644, 60651.
5252
5253 xi) 60628
5254
5255 xii) 60617, 60633, 60827.
5256
5257 2) The Department reserves the right to adjust this geographic area
5258 requirement to assure that:
5259
5260 A) no geographic area remains unserved.
5261
5262 B) the following entities are not excluded from participation as
5263 service providers in the CCP:
5264
5265 i) entities serving limited- or non-English-speaking
5266 participants;

5267
5268 ii) providers that are, or are controlled by, a unit of local
5269 government and cannot operate outside the jurisdiction of
5270 that local government; and
5271
5272 iii) regional benevolent, charitable, social or religious
5273 organizations that have as their charter providing services
5274 to a specific population or geographic area smaller than a
5275 county, township or CCP subarea.
5276
5277 C) transportation to/from adult day service facilities can be completed
5278 in a reasonable period of time.
5279
5280 3) Submit a request for certification providing the information described in
5281 this Section and Sections 240.1600 and 240.1605, in the form and manner
5282 prescribed by the Department, including all required supporting
5283 compliance material or other information documenting its administrative
5284 and operational ability, and institute all necessary action based on the
5285 outcome of the Department's review.
5286
5287 4) Document the legal structure under which it is organized to do business as
5288 set forth in Section 240.1607(h).
5289
5290 5) Provide a list of the directors, officers or owners, as applicable to the legal
5291 structure of the provider agency.
5292
5293 6) Verify experience in providing service comparable to the CCP, as defined
5294 in Sections 240.210, 240.230, 240.235 and 240.237, for which
5295 certification is requested, and that is consistent with the requirements set
5296 forth in this Part.
5297
5298 A) Required Experience
5299
5300 i) For prospective emergency home response service provider
5301 agencies: A minimum of five~~5~~ years experience in
5302 business operations providing emergency home response
5303 service.
5304
5305 ii) For prospective adult day service provider agencies: A
5306 minimum of two~~2~~ years experience providing direct social
5307 services programming.
5308

iii) For prospective in-home service providers: A minimum of three~~3~~ years experience in business operations providing in-home service, one of which must be in Illinois.

iv) For prospective AMD service provider agencies: a minimum of five~~5~~ years experience in business operation providing AMD services.

B) At the Department's discretion, the~~The~~ Department may~~reserves the right to~~:

~~i) adjust the experience requirements specified in subsection (a)(6)(A) if the provider agency submits proof of current accreditation or certification by an appropriate national organization for the service for which Department certification is being requested.~~

i~~ii~~) issue provisional certification to provider agencies, including, but not limited to, those that have not previously been certified or are not in operation at the time the application is made. The provisional certification shall not exceed two years and the Department will conduct additional oversight during the provisional period to protect participant health, safety and welfare. A provider with a provisional certification cannot expand until they have received their first successful review.

ii~~iii~~) adjust the experience requirement (e.g., substituting management team experience for agency experience)~~ when it is in the best interests of the CCP~~. The Department will continue to assure that any adjustment of the experience requirement will occur only when the health, safety and welfare of CCP participants and the quality of services provided will not be adversely affected. The Department will not consider any substituted experience that has been used to support another application.

7) Disclosure of information regarding past business practices of the provider agency and its affiliates, including the managers, directors or owners, relevant to the service applied for, involving, but not limited to, the following circumstances:

5351 A) denial, suspension, revocation or termination for cause of a license
5352 or Provider Agreement, or any other enforcement action, such as
5353 civil court or criminal action;
5354
5355 B) termination of a Provider Agreement or surrender of a license
5356 before expiration or allowing a contract or a license to expire in
5357 lieu of enforcement action;
5358
5359 C) any federal or state Medicaid or Medicare sanctions or penalties
5360 relating to the operation of the agency, including, but not limited
5361 to, Medicaid abuse or fraud;
5362
5363 D) any federal or state civil or criminal felony convictions;
5364
5365 E) operation of an agency that has been decertified in any state under
5366 Medicare or Medicaid; or
5367
5368 F) citations for participant abuse, neglect, injury, financial
5369 exploitation or inadequate care in any state.
5370
5371 8) Document its written policies and procedures in compliance with the
5372 applicable administrative standards imposed on provider agencies under
5373 the CCP, as set forth in Section 240.1510.
5374
5375 9) Document its ability to comply with all applicable responsibilities
5376 imposed on provider agencies under the CCP, as set forth in Section
5377 240.1520, including proof of required insurance coverages.
5378
5379 10) Submit audited financial reports from the last complete business fiscal
5380 year, unless the provider agency is a newly established business entity.
5381
5382 A) Newly established for profit business entities, regardless of
5383 relationship to any other provider agency, shall:
5384
5385 i) submit proof that employee tax accounts are
5386 reestablishedrestablished with the State of Illinois and the
5387 U.S. TreasuryTreasurery; and
5388
5389 ii) submit either:
5390
5391 • a bank approved business plan with approved
5392 financial backing; or
5393

- if financial resources are from individuals, the most recent two~~2~~ years of tax returns, and if applicable~~as well as~~ any bank approved individual financial backing for use in the business.

B) Newly established not-for-profit business entities, regardless of relationship to any other provider agency, shall submit:

i~~1~~) Bank approved business plan with approved financial backing or a signed financial statement illustrating restricted and nonrestricted funding; and

ii~~2~~) Proof that employee tax accounts are established with the State of Illinois and the U.S. Treasury.

11) Submit proof that it is fiscally sound, as that term is defined in Section 240.160, by verifying assets (e.g., audited financial statements with accompanying notes, bank statements, investment statements, or letters of credit from financial institutions) sufficient to cover 90 days of operating expenses for the service line applied for (i.e., specifically ADS, In-Home Services, EHRS or AMD), as defined by the agency business plan. No more than 30 of the 90 days should be based on a line of credit.

12) Provide assurance that its business operations comply with the service, staffing and training requirements imposed on provider agencies under this Part.

13) Provide a minimum of five~~5~~ references from such entities as persons who have been served by the provider, nonprofit or business organizations or governmental bodies that have observed the operations and/or services of the provider, employees of the provider, an Area Agency on Aging, etc., attesting to the provider agency's qualifications relevant to providing CCP services. The references shall be from independent and~~a~~ diverse group of knowledgeable entities. The Department will not accept reference letters from entities or persons who are affiliated with the applicant and/or entities who have common control/owners with the applicant.

14) Comply with all applicable federal, State and local laws, regulations, rules, service standards and policies or procedures pertaining to the provider agency in its business operations and to the services provided under the CCP.

b) If a provider agency is not able or is unwilling to meet the administrative requirements in subsection (a), the Department shall deny its request for certification.

c) The Department reserves the right to accept documentation of Illinois Department of Public Health (DPH) home service licensure for applicable administrative requirements. (See 77 Ill. Adm. Code 245.Subpart B.)

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1510 Provider Administrative Minimum Standards

The provider shall establish and comply with written policies and procedures. Provider policies shall include the following:

a) Confidentiality of participant records is maintained as required by Section 240.340, including:

1) Ensure access to participant records is limited to specific areas within the office and only available to personnel with need for the information.

2) Establish and maintain current and archived files in a secure and confidential manner.

b) The type and amount of service is provided in accordance with the Participant Agreement – Person-centered Plan of Care as developed and authorized by the CCU in collaboration with the participant/authorized representative.

c) Money handling activities related to necessary shopping/errand activities, including receipt procedures, are monitored.

d) Staff development plans that show each job category and include a job description and a wage range plus personnel policies that include benefits, promotion and evaluation criteria so:

1) Each employee is provided a written job description that applies to his/her job category.

2) A copy of current written personnel policies for the specific job category is available to all employees.

3) Each employee is informed of the wage range for the specific job category at the time of employment and upon any subsequent revisions.

4) Employee benefits and grievance procedures are clearly stated in writing and comply with both State and federal regulations.

5) Personnel records are maintained for each employee and include at least the following:

A) employee application;

B) annual face-to-face performance evaluation;

C) documentation of participation in pre-service, in-service and other pertinent training (orientation in agency policies) in accordance with Department training required by Sections 240.1535 and 240.1555;

D) documentation of supervisory visits, quarterly conferences and evaluations;

E) documentation to support qualifications;

F) documentation of vehicle insurance for those employees who provide participant transportation in their own vehicles;

G) documentation that the websites for the federal Department of Health and Human Services (HHS) and HFS, Office of Inspector General, were checked for excluded providers; and

H) documentation of a criminal background check and waiver, if applicable, as required by the Illinois Healthcare Worker Background Check Act [225 ILCS 46] and an online check of the Adult Protective Services Registry, as required by the Adult Protective Services Act [320 ILCS 20/7.5(c)].

e) All Department required documentation to support units of service requested for reimbursement shall be retained in paper or electronic format for a minimum of six~~6~~ years after the ending year for its creation date or the ending year when it was last in effect, whichever is later.

f) Ongoing quality improvement, reviewed at least annually, through:

1) staff and community agency surveys;

5522 2) program and service reviews; and
5523
5524 3) implementation of changes:
5525
5526 A) based upon program and service review findings and submission of
5527 documentation of those changes to the Department, in accordance
5528 with Department policy; and
5529
5530 B) to comply with Medicaid waiver quality assurance regulations.
5531
5532 g) U.S. Department of Labor, Occupational Safety and Health Administration
5533 (OSHA) Regulation (29 CFR 1910.1030) (2008).
5534
5535 h) National Labor Relations Act (29 U.S.C.USC 151-169) and any applicable
5536 collective bargaining agreements.
5537
5538 i) U.S. Department of Homeland Security, U.S. Citizenship and Immigration
5539 Services (8 U.S.C.USC 1324(a) et seq.).
5540
5541 j) Drug Free Workplace Act [30 ILCS 580].
5542
5543 k) Patient Self-Determination Act (42 U.S.C.USC 1396(a) et seq.).
5544
5545 l) Health Care Surrogate Act [755 ILCS 40].
5546
5547 m) Control of the spread of infectious diseases and compliance with universal
5548 precautions.
5549
5550 n) Assure nondiscrimination in accordance with Section 240.320 and the
5551 Department's civil rights program.
5552
5553 o) Develop, maintain and protect administrative and participant records, including
5554 observance of confidentiality in the maintenance and transmission of records, as
5555 required by the Health Insurance Portability and Accountability Act of 1996
5556 (HIPAA) (42 U.S.C.USC 1320d et seq.).
5557
5558 p) Receive and resolve complaints as required by Section 240.1650.
5559
5560 q) Develop an all hazards disaster operations plan to respond to emergency
5561 situations, including, but not limited to, medical emergencies, home or site-related
5562 emergencies, emergencies related to the participant, weather-related emergencies,
5563 and vehicle/transportation emergencies.
5564

5565 r) Adequate supervision of all persons, both staff and volunteers, having direct
5566 service contact, as required by Section 240.1535 or 240.1555, respectively.
5567
5568 s) Mandated reporting of all conditions or circumstances that place the participant,
5569 or the participant's household, in imminent danger (e.g., situations of abuse or
5570 neglect), as required by 89 Ill. Adm. Code 270.
5571
5572 t) Prohibiting the use of seclusion and/or restraint against a participant, unless
5573 supported by documentation in the person-centered plan of care and the
5574 employees have received training on restraint and seclusion practices.
5575
5576 u) Participate in all Department-mandated training for staff and volunteers,
5577 including, but not limited to:
5578
5579 1) Training on universal precautions as required by OSHA (29 CFR
5580 1910.1030) (2008);
5581
5582 2) Training on emergency procedures; and
5583
5584 3) Training for abuse, neglect, exploitation and incident reporting required by
5585 the Adult Protective Services Act [320 ILCS 20].
5586
5587 v) Develop and adhere to marketing standards for services that:
5588
5589 1) require all persons involved with marketing and sales efforts to refrain
5590 from incomplete service comparisons or otherwise misleading
5591 representations (twisting) and high pressure sales tactics (playing on
5592 explicit or implicit fear and threats);
5593
5594 2) ensure the confidentiality and security of sensitive personal identification,
5595 financial and health information of current and prospective program
5596 participants that is obtained during discussions;
5597
5598 3) prohibit unsolicited telephone calls (cold-calling) and door-to-door
5599 solicitations; sales activities, as opposed to educational or informational
5600 activities, at community meetings, educational events and health care
5601 facilities; and cross-selling of non-CCP-related services to current and
5602 prospective participants in the program;
5603
5604 4) prohibit the use of independent agents for marketing of CCP-related
5605 services to participants; and
5606
5607 5) limit the value of any incentives and promotional products offered to

5608 current and prospective participants in the program.
5609
5610 w) Documentation that employees having direct contact with participants are
5611 annually educated about: the significant risks (including death) frail older adults
5612 face when exposed to the influenza virus; the steps homecare aides can take to
5613 minimize the risks of exposure, including immunizations; and the locations of
5614 resources within the provider's service area where immunizations are available,
5615 highlighting those that offer the vaccination for free or nominal costs. The
5616 provider shall maintain records of employees with direct participant contact who
5617 have received influenza vaccine by January 31 of each calendar year.
5618
5619 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
5620
5621 **Section 240.1520 Provider Responsibilities**
5622
5623 a) CCP services shall be purchased only from providers certified by the Department
5624 to provide those services.
5625
5626 b) Providers shall carry occurrence based general liability insurance in the single
5627 limit minimum amount of $1,000,000 per occurrence, $3,000,000 in the
5628 aggregate.
5629
5630 c) Providers shall also carry the following insurance coverages:
5631
5632 1) worker's compensation for direct service staff;
5633
5634 2) volunteer protection equivalent to employees' coverage, including
5635 coverage for volunteer drivers/escorts, if applicable; and
5636
5637 3) motor vehicle liability, uninsured motorist and medical payments, if
5638 agency staff transport participants in agency vehicles, or proof of
5639 minimum motor vehicle liability, uninsured motorist and medical
5640 payments, if agency staff transport participants in the staffs' own vehicles.
5641
5642 d) The policies or current letters documenting all provider agency insurance
5643 coverage and policies or current letters documenting staff coverage specified in
5644 subsection (b) or (c) shall be available to the Department upon request.
5645
5646 e) All providers of CCP services must comply with all applicable local, State and
5647 federal statutes, rules and regulations.
5648
5649 f) A provider shall provide services to all CCP participants referred by the CCU,
5650 with the following exceptions:

1) The person-centered plan of care is determined to be inappropriate in the professional judgement of the provider.

   A) The provider shall immediately notify the CCU of the provider's assessment and evaluation of the situation.

   B) The provider and the CCU shall work together to determine if a person-centered plan of care that adequately meets the participant's needs can be developed.

   C) In the event the provider and the CCU cannot reach an agreement, the Department shall be contacted and shall determine the final resolution.

2) The provider is unable to accept all CCP referrals.

   A) The provider shall request a cap on the number of participants to be served (service cap), in writing, to the Department.

   B) The Department will not approve a service cap for a provider that is the only provider of in-home service in the service area or when it is not in the best interest of the program.

   C) Upon approval of the request, the provider assumes responsibility for managing intake to maintain the cap.

g) Any temporary change or deviation from the person-centered plan of care must be documented by the provider in the participant's file. A provider shall not deviate from the participant's person-centered plan of care without receipt of verbal (followed up, within two~~2~~ working days, with written instruction to be placed in the participant's file) or written instruction from the Department or the CCU, except in cases of emergency, refusal of service or failure of a participant to be home to receive service.

h) It shall be the responsibility of the provider to advise the CCU of any change in the participant's physical/mental/environmental needs that the provider, through the direct service worker/supervisor, has observed, when the change would affect the participant's eligibility or service level or would necessitate a change in the person-centered plan of care.

i) All providers shall reply to requests by a participant, by telephone or in writing, within 15 calendar days after the date of the request. The request and the

response shall be documented in the participant's file.

j) Providers shall electronically submit a Vendor Request for Payment (VRFP) that shall be received by the Department no later than the 15th day of the month following the month in which services were provided.

1) The VRFP shall state the number of units of service provided to each identified participant during the service month.

2) Providers shall be reimbursed by the Department for the entire rate for each unit of service. Providers shall bill the Department for service rendered to participants in increments of quarter units.

k) Providers shall provide the Department with an annual audit report to be completed by an independent ~~Certified Public Accountant (~~CPA~~)~~ and in accordance with 74 Ill. Adm. Code 420.Subpart D. The audit report shall be filed at the main office of the~~ Illinois~~ Department~~ on Aging, Springfield, Illinois~~, within six~~6~~ months after the date of the close of the provider's business fiscal year.

l) Providers must accept all correspondence from the Department. Failure to do so may lead to contract action~~ (see Section 240.1665)~~.

m) Records

1) Providers must maintain records for administration, audit, budgeting, evaluation, operation and planning efforts by the Department in offering CCP services, including:

A) records of all CCP referrals to the provider, including the disposition of each referral;

B) records for participants, which shall include, but are not limited to, applicable forms as required by the Department;

C) administrative records, including:

i) data used by the Department to provide information to the public;

ii) service utilization;

iii) complaint resolution; and

5737
5738 iv) billing and payment information, plus the underlying
5739 documentation to support the units of service submitted to
5740 the Department for reimbursement.
5741
5742 2) These records shall be available at all times to the Department, HFS, HHS,
5743 and/or any designees, and shall be maintained for at least six~~6~~ years after
5744 the termination date of the Provider Agreement. Any records being
5745 maintained under this subsection (m) by a provider who ceases to provide
5746 the agreed services shall be transmitted in accordance with Subpart K.
5747
5748 n) Providers must notify the Department within seven~~7~~ days after any change in
5749 agency information (e.g., acquisition, assignment, consolidation, merger, sale of
5750 assets or stock, transfer, etc.) or contact information (e.g., address, telephone, fax,
5751 email address, contact person, authorized representative, etc.).
5752
5753 1) Providers must notify the Department at least 30 days in advance of any
5754 relocation of their administrative office.
5755
5756 2) Providers must submit documentation of changes in provider name,
5757 corporate structure and/or Federal Employer Identification Number to the
5758 Office of General Counsel. This documentation shall be reviewed to
5759 determine if an assignment of the Provider Agreement has occurred (see
5760 Section 240.1607(k)).
5761
5762 o) Providers must conduct a criminal background check, as required by the Illinois
5763 Healthcare Worker Background Check Act; an online check of the Adult
5764 Protective Services Registry, as required by the Adult Protective Services Act
5765 [320 ILCS 20/7.5(c)]; and a check of the HHS exclusion database and the HFS
5766 Office of Inspector General database on all agency staff and all regularly
5767 scheduled volunteers having access to financial information or one-on-one contact
5768 with CCP participants.
5769
5770 1) Provider agencies shall comply with the requirements of the Health Care
5771 Worker Background Check Act and the Adult Protective Services Act.
5772
5773 2) Staff refusing to submit to a background check shall not have contact with
5774 CCP participants in any capacity.
5775
5776 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
5777
5778 **Section 240.1530 General In-home Service Staffing Requirements**
5779

5780 a) Each in-home service provider shall have specified staff adequate in number to
5781 comply with Section 240.1520(f) to carry out the following functions:
5782
5783 1) A designated individual who has responsibility for administration of the
5784 CCP in-home service program.
5785
5786 2) Qualified in-home service staff to meet the needs of all cases referred for
5787 the provision of in-home services. In determining what services are
5788 sufficient, the Department shall look to whether in-home services are
5789 adequate. Inadequate in-home services are characterized by delays or
5790 interruptions in the provision of in-home services or by failure to provide
5791 in-home services as required by the person-centered plan of care.
5792
5793 b) The in-home service provider shall assign responsibilities to staff, including the
5794 following:
5795
5796 1) Planning and administration of the in-home service program; assuring
5797 adequate staff to provide required services at all times; serving as liaison
5798 between the staff and the community; implementing policies according to
5799 regulations promulgated by the Department that govern the program;
5800 recommending policy and program changes to the Department; and
5801 recruiting, training and supervising staff.
5802
5803 2) Supervising of homecare aides shall be accomplished by qualified staff
5804 who have responsibility to ensure that the aides are scheduled and that
5805 assignments are kept.
5806
5807 c) Each in-home service provider shall ensure that supervisors maintain a maximum
5808 15-minute response time when homecare aides they supervise are serving in a
5809 participant's home and request information, assistance or direction as it relates to
5810 the participant's status, health or welfare. A supervisor must be available to
5811 respond to a homecare aide by available technology, such as by the participant's
5812 phone, or the aide's/provider's electronic equipment, email, cell phone, 24/7 live
5813 answering system, two-~~2-~~way radio, or any other similar or suitable technology,
5814 according to the provider's written procedures.
5815
5816 d) In-home service providers shall not subcontract for management, supervisory or
5817 in-home staff.
5818
5819 e) In-home service providers shall make one~~1~~ hour service segments available when
5820 needed to meet participant needs.
5821
5822 f) Electronic Visit Verification

1) The Department requires in-home service providers to maintain electronic visit verification (EVV), based on global positioning systems or other cost-effective technology, for monitoring and verifying the work schedules of, and the work performed by, all homecare aides.

2) EVV systems must meet the requirements set forth in Section 240.1531.

g) In-home service providers shall make evening and weekend service available to CCP participants as required by the person-centered plan of care.

1) Evening service shall be available until at least 8 p.m. Monday through Friday.

2) Weekend service shall be available from at least 8 a.m. until 8 p.m. on Saturday and Sunday.

3) Provider offices are not required to be open for business during evening and weekend hours; however, a supervisor must be on-call and available whenever service is being provided.

h) In-home service providers shall provide escort/transportation when required by the person-centered plan of care.

i) In-home~~Subject to the following restrictions, in-home~~ service providers may hire relatives and legal guardians of a participants, legally responsible individuals,~~family caregivers of participants~~, or homecare aides who are recommended by a participant~~participants~~, once they have met all applicable CCP requirements and any other agency employment requirements. A relative, legal guardian, legally responsible individual, or homecare aide who is recommended by the participants shall not be required to care for other participants served by the in-home service provider.~~:~~

~~1) A family caregiver shall not be required to care for other participants served by the in-home service provider agency.~~

~~2) A family caregiver cannot be the spouse of, or otherwise legally responsible for, a participant.~~

j) In-home service providers shall report and regularly update, as required by law, any registry of individuals certified as homecare aides (e.g., the DPH Health Care Worker Registry).

5866 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
5867
5868 **Section 240.1531 Electronic Visit Verification (EVV) Requirements for In-home Service**
5869 **Providers**
5870
5871 a) EVV is based on global positioning systems or other cost-effective technology
5872 and secure applications for monitoring work schedules of homecare aides
5873 supplied by and paid for by the in-home service provider agency, including:
5874
5875 1) cellular phone or other mobile devices with activated global positioning
5876 systems;
5877
5878 2) Telephony/Integrated Voice Recognition (IVR); or
5879
5880 3) an alternative auditable technology when a phone is not available in the
5881 participant's home, such as, but not limited to, a fixed visit verification
5882 device installed in the participant's home.
5883
5884 b) An EVV system must meet the following minimum standards:
5885
5886 1) Functional Capacity
5887
5888 A) Verification of Hours Worked
5889
5890 i) The system must maintain accurate time reporting and
5891 allow for review/approval of time by the participant or
5892 participant designee, including participants with visual and
5893 physical disabilities.
5894
5895 ii) The system must allow the participant or designee to
5896 manually or electronically verify that services were
5897 delivered and that time reporting is accurate.
5898
5899 B) Multiple Input Options
5900
5901 i) The system must include electronic verification options,
5902 including a cellular phone or other mobile devices with
5903 activated global positioning systems, telephony/IVR, or an
5904 alternative auditable technology, when a phone is not
5905 available in the participant's home, such as, but not limited
5906 to, a fixed visit verification system installed in the
5907 participant's home for authentication purposes.
5908

5909 ii) The electronic verification options must include the ability
5910 to create and manage related work schedule timesheets and
5911 participant service calendars, as authorized in the
5912 participant's person-centered plan of care.
5913
5914 C) Flexibility
5915
5916 i) The system must support the addition of services,
5917 participants, and homecare aides, as needed.
5918
5919 ii) The system must accommodate multiple participants and/or
5920 service provider agencies.
5921
5922 iii) The system must accommodate multiple work shifts (e.g.,
5923 more than one~~1~~ participant and/or homecare aide in the
5924 same home or at the same phone number; participants and
5925 homecare aides who live at the same address; multiple
5926 work shifts per day per participant/homecare aide
5927 combination; homecare aides who work for multiple
5928 participants; and participants who have multiple homecare
5929 aides).
5930
5931 D) Capacity
5932
5933 i) The system must record new EVV data.
5934
5935 ii) The system must retain all EVV data for up to six~~6~~ years
5936 from the last date of service.
5937
5938 iii) The system must retrieve archived data in a timely manner.
5939
5940 E) Tracking
5941
5942 i) The system must document and track unedited sign-in and
5943 sign-out times of all homecare aide visits.
5944
5945 ii) The system should allow for multiple sign in/out activities
5946 per day to accommodate time tracking for breaks in service,
5947 meals, and other service provider agency reporting
5948 requirements.
5949
5950 F) Recording Increments: The system must record homecare aide
5951 visits in quarter-hour increments and bill to the nearest quarter-

5952 hour, consistent with the federal Fair Labor Standards Act (29
5953 USC 201) and related regulations (29 CFR 785.48(b)).
5954
5955 G) Identification (ID) Capture: The system must electronically
5956 capture all relevant service visit data, including:
5957
5958 i) participant ID;
5959
5960 ii) service provider agency ID;
5961
5962 iii) homecare aide ID;
5963
5964 iv) date and time that service delivery begins and ends;
5965
5966 v) location of the service; and
5967
5968 vi) CCU and Care Coordinator ID.
5969
5970 H) Access: The system must be accessible for input and/or service
5971 approval 24-hours per day, 7 days per week for participants and
5972 homecare aides with hearing, physical or visual impairments.
5973
5974 I) Alerts: The system must notify supervisory staff at the service
5975 provider agency of any untimely and missed shifts or deviation in
5976 schedules.
5977
5978 2) Billing Integration and Data Sharing
5979
5980 A) Real-Time Data
5981
5982 i) The system must enable service provider agencies to obtain
5983 real-time data to arrange regular scheduled visits.
5984
5985 ii) The system must enable service provider agencies to
5986 respond in a timely manner to missed visits to ensure
5987 reliability in the delivery of care.
5988
5989 iii) The system must enable the use of the recorded EVV data
5990 for billing, verification, automated billing, and improved
5991 administrative efficiencies.
5992
5993 B) Secured Transaction Data
5994

5995 i) The system must enable service provider agencies to
5996 upload transactions data to the Department in a secured
5997 manner that would facilitate, at a minimum, daily billing
5998 data.
5999
6000 ii) The system must enable service provider agencies to
6001 securely handle internal billing and/or payroll functions
6002 pursuant to the recorded EVV data.
6003
6004 C) Modifications and Adjustments
6005
6006 i) The system must track and report modifications after the
6007 direct care staff input their time.
6008
6009 ii) The system must record justification of manual time
6010 reporting adjustments or exceptions.
6011
6012 D) Reports and Queries
6013 The system must create user-friendly reports and data files that
6014 enable the service provider agency and Department staff to run
6015 data queries and facilitate management reports.
6016
6017 3) Data Storage and Security
6018
6019 A) Confidentiality
6020 The system must be compliant with electronic data interchange
6021 standards for electronic healthcare transactions pursuant to the
6022 Medicaid Information Technology Architecture under the Health
6023 Insurance Portability and Accountability Act to ensure security of
6024 confidential participant information and medical data.
6025
6026 B) Backup and Recovery
6027
6028 i) The system must maintain reliable backup and recovery
6029 processes in the event of a system malfunction or disaster
6030 situation.
6031
6032 ii) The system must provide an alternative system for
6033 timekeeping due to a service provider agency's temporary
6034 failure or inability to use the system for a start or end of the
6035 homecare aide's shift.
6036
6037 4) Electronic Reporting Interface

6038
6039 A) The system must be able to provide a secured interface to transmit
6040 the EVV visits to the Department's electronic Community Care
6041 Program Information System.
6042
6043 B) The interface file must include the homecare aide's Social Security
6044 Number or another unique personal identifier acceptable to the
6045 Department, visit start times and end times, and any other billing
6046 data required by the Department.
6047
6048 5) Disaster Recovery
6049
6050 A) The EVV system must maintain a Disaster Recovery Plan that
6051 complies with electronic data interchange standards for electronic
6052 healthcare transactions pursuant to the Medicaid Information
6053 Technology Architecture under the Health Insurance Portability
6054 and Accountability Act, identifying every resource that requires
6055 backup, to what extent backup is required and that conducts
6056 backup minimally on a daily basis in the event of a system failure.
6057
6058 B) The plan must include offsite electronic and physical storage in the
6059 United States, preferably in Illinois, and should include, at a
6060 minimum, the following:
6061
6062 i) recovery procedures for all events ranging from a minor
6063 malfunction to a major disaster;
6064
6065 ii) for offsite environments, roles and responsibilities of
6066 vendor and outsourcer staff;
6067
6068 iii) checkpoint/restart capabilities;
6069
6070 iv) retention and storage of backup files and software;
6071
6072 v) hardware backup for the main processor;
6073
6074 vi) application and operating system software libraries,
6075 including related documentation;
6076
6077 vii) identification of the core business processes involved in the
6078 system;
6079
6080 viii) documentation of contingency plans;

6081
6082 ix) definition of triggers for activating contingency plans; and
6083
6084 x) plan for replacement of hardware and software.
6085
6086 6) A system is subject to review and audit by the Department.
6087
6088 c) An in-home service provider agency must adopt internal policies and procedures
6089 regarding the EVV system.
6090
6091 d) An in-home service provider agency must provide training resources and
6092 technical support for their employees on the proper utilization of their EVV
6093 systems.
6094
6095 e) An in-home service provider agency must provide help desk or call center access
6096 for participants and homecare aides regarding the delivery of services.
6097
6098 f) All in-home service provider agencies are required to file certification and
6099 documentation with the Department to verify compliance and implementation of
6100 their EVV system.
6101
6102 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
6103
6104 **Section 240.1535 In-home Service Staff Positions, Qualifications, Training and**
6105 **Responsibilities**
6106
6107 a) Homecare Supervisor
6108
6109 1) Activities of a homecare supervisor shall include:
6110
6111 A) documenting participant contacts and activities related to
6112 participant services in the participant's file;
6113
6114 B) preparing or reviewing reports and service calendars;
6115
6116 C) monitoring receipt procedures in the conduct of essential shopping
6117 and errands as stated in the person-centered plan of care;
6118
6119 D) providing input to the care coordinator on the services that are
6120 needed for each participant as a result of conferences with the
6121 homecare aide or in-home visits;
6122
6123 E) planning, preparing and documenting contact and quarterly

6124 conferences with each assigned homecare aide;
6125
6126 F) evaluating each assigned homecare aide annually;
6127
6128 G) coordinating the homecare aide's activities with other components
6129 of the person-centered plan of care as required;
6130
6131 H) making and documenting semi-annual in-home supervisory visits
6132 to a participant's home for each assigned homecare aide;
6133
6134 I) making home visits, as necessary, to provide hands-on training and
6135 assistance; and
6136
6137 J) initiating and/or participating in participant staffing discussions
6138 with the case manager, as necessary.
6139
6140 2) Qualifications for a homecare supervisor shall include:
6141
6142 A) a high school diploma or general education diploma;
6143
6144 B) combination of skills and experience that indicate that the
6145 participant has the ability to perform the supervisory activities; and
6146
6147 C) certification of completion of Department sponsored CCP training
6148 required by subsection (a)(3)(A).
6149
6150 3) Homecare supervisors shall meet the following training requirements:
6151
6152 A) Within 90 calendar days after the date of employment with the
6153 provider agency in a homecare supervisor position, each supervisor
6154 shall complete Department sponsored CCP training on policy and
6155 procedures, billings, evaluations, homecare aide and participant
6156 files; ~~and~~
6157
6158 B) Within each calendar year, each supervisor shall complete 26~~24~~
6159 hours of documented in-service training on aging related subjects,
6160 including documented participation in in-house staff training
6161 and/or local, State, regional or national conferences. Two of those
6162 hours shall be dementia training which shall include subjects
6163 related to Alzheimer's Dementia and Related Disorders; Safety
6164 Risks; and Communication and Behavior. At~~In-service supervisor~~
6165 ~~training shall include at~~ least 16 of the remaining hours of training
6166 shall be selected from among the following topics:

6167
6168 i) Promoting participant dignity, independence, self-
6169 determination, privacy, choice and rights;
6170
6171 ii) Person-centered care planning;
6172
6173 iii) Special characteristics of the elderly population; physical,
6174 emotional and developmental needs of the participant;
6175
6176 iv) Recognizing participant abuse, neglect, exploitation, and
6177 self-neglect; abuse and neglect prevention and reporting
6178 requirements;
6179
6180 v) Communication skills;
6181
6182 vi) Universal precautions, blood-borne pathogens and infection
6183 control;
6184
6185 vii) Fire and life safety, including emergency procedures to be
6186 implemented under the agency's all hazards disaster
6187 operations plan;
6188
6189 viii) Dealing with adverse behaviors (e.g., mental illness,
6190 depression and aggression);
6191
6192 ix) Family dynamics;
6193
6194 x) Diseases of the elderly; ~~understanding Alzheimer's Disease
6195 and dementia;~~
6196
6197 xi) Body mechanics and normal range of motion, transfer
6198 techniques and positioning;
6199
6200 xii) Chronic illness, death and dying;
6201
6202 xiii) Medicaid fraud and abuse;
6203
6204 xiv) Appropriate and safe techniques in performing and
6205 assisting with personal care;
6206
6207 xv) First aid and/or cardiopulmonary resuscitation (CPR);
6208
6209 xvi) Understanding advance directives;

6210
6211 xvii) Respiratory services;
6212
6213 xviii) Use of seclusion and restraint.
6214
6215 b) Homecare Staff
6216
6217 1) Activities of homecare aides include the following:
6218
6219 A) following a participant's written person-centered plan of care;
6220
6221 B) carrying out duties as assigned by the supervisor;
6222
6223 C) observing the participant's functioning and reporting to the
6224 homecare supervisor;
6225
6226 D) providing necessary receipts and documentation in the conduct of
6227 essential shopping/errands;
6228
6229 E) maintaining records of daily activities, observations, and direct
6230 hours of service; and
6231
6232 F) attending pre-service training, in-service training sessions and staff
6233 conferences.
6234
6235 2) Qualifications of a homecare aide shall include:
6236
6237 A) one of the following types of education or experience:
6238
6239 i) a high school diploma or general education diploma;
6240
6241 ii) one year of employment in a comparable human service
6242 capacity, or experience in care for a dependent child or
6243 adult family member; or
6244
6245 iii) demonstration of continued progress towards meeting the
6246 educational requirement of a general education diploma by
6247 current registration and evidence of successful completion
6248 of course work (successful completion means achievement
6249 of a grade of "C" or higher); and
6250
6251 B) the training required in subsection (b)(3).
6252

6253 3) Homecare aides shall meet the following training requirements:
6254
6255 A) ~~new employees shall receive~~ 24 hours of initial pre-service
6256 training, including agency orientation of not more than two~~2~~ hours,
6257 prior to assignment to provide services to a CCP participant
6258 without a supervisor or trainer present (not to exceed a six~~6~~ month
6259 period from the training to first assignment). Initial homecare aide
6260 training shall be subject to a competency evaluation conducted by
6261 the agency and include all in-home services (see Section 240.210),
6262 as well as the following additional topics:
6263
6264 i) The homecare aide's job responsibilities and limitations;
6265
6266 ii) Communication skills, including communicating with
6267 special participant populations such as the hearing impaired
6268 and participants with dementia or other special needs;
6269
6270 iii) Observation, reporting and documentation of participant
6271 status and of the service furnished;
6272
6273 iv) Performance of specific service components of in-home
6274 services authorized under Section 240.210(a), including,
6275 but not limited to, personal care tasks for participants that
6276 are not medical in nature (e.g., shaving, hair shampooing
6277 and combing, bathing and sponge bath, shower bath or tub
6278 bath, toileting, dressing, nail care, respiratory services,
6279 brushing and cleaning teeth or dentures and preparation of
6280 appropriate supplies, positioning/transferring participant,
6281 and assisting participant with exercise/range of motion);
6282
6283 v) Ability to assist in the use of specific adaptive equipment,
6284 if the aide will be working with participants who use the
6285 device;
6286
6287 vi) Basic hygiene and basic infection control practices;
6288
6289 vii) Maintenance of a clean, safe and healthy environment;
6290
6291 viii) Basic personal and environmental safety precautions;
6292
6293 ix) Use of seclusion and restraint;
6294

x) Recognizing emergencies and knowledge of emergency procedures;

xi) Confidentiality of participant personal, financial and health information;

xii) Knowledge and understanding of abuse and neglect prevention and reporting requirements;

xiii) Respiratory services;

B) a new employee may be exempt from pre-service training, but not mandated dementia training, if the employee:

i) has had previous documented and supervised training within the past two~~2~~ years prior to this employment, equivalent to 24 hours of homecare aide pre-service training, as determined by the provider with appropriate documentation in the employee's personnel file; or

ii) has a valid~~successfully completed~~ RN, LPN, MD, physician assistant license or certification as a CNA ~~training in the past~~ and has been employed in the field within the past two~~2~~ years; or

iii) has been employed as a CCP homecare aide within the past year;

C) ~~thereafter,~~ a minimum of 14~~12~~ hours per calendar year of interactive, (face-to-face, audiovisual presentations, computer-based instruction, etc.) in-service training approved by the provider agency shall be mandatory for all homecare aides. Two of those hours shall be mandatory dementia training which shall include subjects related to Alzheimer's Dementia and Related Disorders; Safety Risks; and Communication and Behavior. Pre-service training shall fulfill the first three~~3~~ hours of in-service training required for new employees, except for homecare aides exempted under subsection (b)(3)(B). In-service training for homecare aides shall include at least 9 hours of training selected from among the following topics:

i) Promoting participant dignity, independence, self-determination, privacy, choice and rights;

ii) Special characteristics of the elderly population; physical, emotional and developmental needs of the participant;

iii) Recognizing participant abuse, neglect and/or exploitation; abuse and neglect prevention and reporting requirements;

iv) Confidentiality of participant information;

v) Communication skills;

vi) Universal precautions, blood-borne pathogens and infection control;

vii) Fire and life safety, including emergency procedures to be implemented under the agency's all hazards disaster operations plan;

viii) Dealing with adverse behaviors (e.g., mental illness, depression and aggression);

ix) Family dynamics;

x) Diseases of the elderly; ~~understanding Alzheimer's Disease and dementia;~~

xi) Body mechanics and normal range of motion, transfer techniques and positioning;

xii) Chronic illness, death and dying;

xiii) Medicaid fraud and abuse;

xiv) Cultural diversity;

xv) Food, nutrition and meal planning and preparation, including special diets;

xvi) Maintenance of a clean, safe and healthy environment, including laundry and house cleaning skills;

xvii) Appropriate and safe techniques in performing and assisting with personal care;

xviii) Assistance with self-administered medications;

xix) Recognizing changes in bodily functions that should be reported to the supervisor;

xx) Respiratory services;

xxi) Use of seclusion and restraint;

xxii) First aid and/or CPR;

xxiii) Understanding advance directives; and

D) progress toward certification in a related field (e.g., CNA) may be used for up to three~~3~~ hours of in-service training per calendar year.

4) All provider employees not in receipt of Department training certificates must complete two hours of dementia training within 30 days of the start of their employment and every calendar year thereafter. This training must include the following subjects: Alzheimer's Dementia and Related Disorders; Safety Risks; and Communication and Behavior.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1541 Minimum Equipment Specifications for Emergency Home Response Service

a) All EHRS equipment must be tested, approved, conform to current industry standards, and meet the requirements in the Department's EHRS equipment and service policies. ~~and listed to meet Underwriters Laboratories safety standards for home health care signaling equipment, UL 1637 (available from Underwriters Laboratories, 2600 N.W. Lake Rd., Camas WA 98607-8542, 877/854-3577; October 26, 1998, no later amendments or editions included), and digital alarm communicator systems units, UL 1635 (January 31, 1996, no later amendments or editions included), if applicable.~~

b) All home units must be capable of signaling from both the activation device remote and the base unit.

c) Activation Device Specifications

6423 1) The activation device must be a portable and water-resistant~~waterproof~~
6424 type of wireless remote that conforms to current industry standards and
6425 meet the requirements in the Department's EHRS equipment and service
6426 policies.~~configured with:~~
6427
6428 ~~A) a crystal or Surface Acoustic Wave (SAW) resonator controlled~~
6429 ~~transmitter frequency for long-term reliability;~~
6430
6431 ~~B) digital encoding capability for at least 10 combinations sufficient~~
6432 ~~for high density situations;~~
6433
6434 ~~C) a minimum transmission range of 300 feet;~~
6435
6436 ~~D) an internal battery capable of operating as a power source for a~~
6437 ~~minimum 5 years;~~
6438
6439 ~~E) a low battery charge signal; and~~
6440
6441 ~~F) components certified as appropriate by the Federal~~
6442 ~~Communications Commission under 47 CFR 15 (2008).~~
6443
6444 2) The activation device must be capable of conducting automatic battery
6445 testing and transmitting the results through the base unit to the support
6446 center on a regular basis.
6447
6448 3) An adaptive version of the activation device must be available that can be
6449 used by hearing, mobility and visually-impaired participants.
6450
6451 d) Base Unit Specifications
6452
6453 1) The base unit must conform to current industry standards and meet the
6454 Department's requirements including~~have~~:
6455
6456 ~~A) an integrated unit that connects to either a rotary dial or touchtone~~
6457 ~~telephone via a modular jack that does not interfere with the~~
6458 ~~normal use of the telephone;~~
6459
6460 ~~B) an Underwriters Laboratory (UL) approved plug as the connector~~
6461 ~~to a standard residential electrical outlet for its power supply;~~
6462
6463 ~~C) an appropriate connection for a seizure line jack so the support~~
6464 ~~center can be signaled even in the event the telephone receiver is~~
6465 ~~off its hook;~~

A~~D~~) an easily identifiable indicator~~"ready" light~~ to verify whether the batteries on the activation device and base unit are charged;

B~~E~~) an easily identifiable indicator~~"confirmation" light~~ that notifies the participant~~indicates~~ when the support center has received a signal;

C~~F~~) a battery that automatically charges whenever the base unit is powered and that maintains a charge for at least 12 hours when the electric power to the base unit is interrupted;

D~~G~~) transmission capability to signal the support center if the base unit battery fails or has a low charge, or electric power to the base unit is interrupted;

~~H) a configuration that allows signaling service through 1 base unit for up to 2 participants in a home;~~

E~~I~~) the ability to allow two-way~~microphone and speaker to enable 2-way voice~~ communication between the participant's home and the support center. The support center must be able to control both the microphone sensitivity and speaker volume; and

F~~J~~) appropriate certification by the Federal Communications Commission under 47 CFR 15~~ (2008)~~ and 47 CFR 68~~ (2008)~~.

2) The base unit must give both audible and visual confirmation of the signal status using digitized voice technology and lighting cues to help the participant stay calm while waiting on his or her designated emergency contact~~responder~~ or other appropriate response to the situation directed by the support center.

3) The base unit must reattempt signaling on a regular basis until the support center confirms its receipt.

e) Support Center Specifications

1) The EHRS support center must have back-up monitoring capacity to take over all monitoring functions and handle all incoming emergency signals. ~~The back-up monitoring center must be at a location different from the primary center, on a different power grid system and on a different telephone trunk line.~~ It must have a back-up battery and electrical generating capacity, as well as telephone line monitoring abilities.

6509
6510 2) All EHRS support center and back-up center equipment, at a minimum,
6511 must:
6512
6513 A) monitor the EHRS system for the receipt of incoming signals from
6514 connected base units in participants' homes, including test
6515 transmissions and fault conditions, on a continuous basis;
6516
6517 B) have an audible and visual alarm for the notification of all
6518 ~~incoming~~ signals, including test transmissions and fault conditions;
6519
6520 C) direct an appropriate response within one~~a~~ minute of the receipt of
6521 a signal as an operational average without disrupting or
6522 terminating the connection to the base unit in the participant's
6523 home, 24 hours a day, 365 days a year, including interpretation
6524 services and communication facilitated by a teletypewriter (TTY)
6525 communication device for individuals experiencing hearing loss or
6526 impairment~~the deaf~~;
6527
6528 D) provide technical support as required, 24 hours a day, 365 days a
6529 year;
6530
6531 E) identify each participant and simultaneously record all
6532 communication among the participant, support center and
6533 responder, as applicable, for all signals, including test
6534 transmissions and fault conditions;
6535
6536 F) display, print and archive the participant identifier, date, time,
6537 communication and response period for each incoming signal,
6538 which must be maintained for at least a three ~~3-~~year period for
6539 quality control and liability purposes;
6540
6541 G) have an uninterruptible power supply ~~(UPS)~~ back-up that will
6542 automatically take over system operation in the event electric
6543 power to the support center is interrupted, other type of
6544 malfunction occurs, or repairs are needed. The back-up power
6545 supply must be sufficient to operate the entire system for a
6546 minimum of 12 hours;
6547
6548 H) have separate and independent primary and back-up receivers,
6549 computer servers, databases, and other components to provide an
6550 uninterruptible monitoring system in the event of equipment
6551 malfunction;

I) perform self-diagnostic testing for malfunctions in equipment in participant homes and at the support center, and for fault conditions in the primary and back-up operating systems and power supply at the support center, that could interfere with receiving and responding to signals, such as non-operational receivers and transmitters, signals received with no communications, telephone line outages, power loss, etc.; and

J) maintain appropriate certification by the Federal Communications Commission under 47 CFR 15 and 47 CFR 68.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1542 Administrative Requirements for Emergency Home Response Service Providers

a) In order to qualify for certification, a provider agency must, to the satisfaction of the Department:

1) meet the administrative requirements under Section 240.1505;

2) meet the certification requirements under Section 240.1600 or 240.1605;

3) provide assurance that its equipment and support center are in continual compliance with the technology requirements imposed~~ on provider agencies~~ under Section 240.1541;

4) maintain adequate records for administration, audit, budgeting, evaluation, operation and planning efforts by the Department in offering EHRS as a service through the CCP, including participant records, which shall include, but are not limited to:

A) dates and times of all signaling, and the name of the emergency responder for each signaling;

B) dates and times of all equipment tests; and

C) disposition of all emergency signaling;

5) ensures equipment complies with the current industry standards and meets the requirements in the Department's equipment and service policies;~~comply with the following requirements:~~

~~A) this Part;~~

~~B) Underwriters Laboratories safety standards for home health care signaling equipment, UL 1637; and~~

~~C) Underwriters Laboratories safety standards for digital alarm communicator systems units, UL 1635.~~

6) complete management training provided by the Department or its designee:

A) Training shall be completed by management staff (e.g., managers, supervisors, billing agents) of the EHRS provider prior to the award of a ~~CCP~~ EHRS contract ~~from the Department~~;

B) At a minimum, the individuals~~individual~~ responsible for administration of the ~~CCP~~ EHRS program at the provider agency shall complete this training;

C) The Department is authorized to charge a reasonable fee for this training to cover related administrative costs.

b) If a EHRS provider ~~agency~~ is not able to meet these administrative requirements, then the Department shall deny its request for a certification of qualifications under Section 240.1600.

c) All employees of an EHRS provider must complete two hours of dementia training within 30 days of the start their employment and every calendar year thereafter. This training must include the following subjects: Alzheimer's Dementia and Related Disorders; Safety Risks; and Communication and Behavior.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1543 Minimum Equipment Specifications for Automated Medication Dispenser Service

a) An AMD unit/equipment must be capable of portability to be temporarily transferred to another non-institutional residence in Illinois without additional fees.

b) AMD Unit Specifications

1) The AMD unit must be a portable mechanical system configured with:

A) all the cords and interfaces needed for installation;

B) an internal battery:

i) capable of operating as a power source for a minimum of three~~3~~ years;

ii) that automatically charges whenever the base unit is powered; and

iii) maintains a charge for at least 12 hours when the electric power to the base unit is interrupted;

C) the ability to verify whether the batteries on the base unit are charged and when the battery charge is low;

D) components certified as appropriate by the Federal Communications Commission (FCC) under 47 CFR 15 and 68;

E) appropriate Underwriters Laboratories (UL) safety standards (UL 60950 and 60950-1) certification for battery powered technology equipment;

F) an integrated unit that connects to either a telephone line or wireless/cellular system that does not interfere with the normal use of the telephone or other devices using the telephone line, such as Emergency Home Response Service;

G) an Underwriters Laboratory (UL) approved plug as the connector to a standard residential electrical outlet for its power supply; and

H) transmission capability to signal the support center or notify the participant/authorized representative/assisting party if the base unit battery fails or has a low charge, or if electric power to the base unit is interrupted.

2) The AMD unit must have the following operating features:

A) ability to be loaded, programmed and changed to add and remove medications, including:

i) local or remote programming accessibility;

ii) medication dispensed at least four~~4~~ times a day; and

iii) alerting the participant at the times programmed for dispensing medication;

B) ability to be filled with medications, including:

i) holding at least seven~~7~~ days' supply of medications;

ii) holding multiple medications in individual compartments;

iii) access to medication for an early dose option; and

iv) locking after the medication is loaded;

C) ability to alert the participant when it is time to take medications at least every five~~5~~ to ten~~10~~ minutes for at least 60 minutes until the dose is taken or the dose is locked, including:

i) using verbal, auditory or visual prompts such as flashing lights and audible tones or verbal instructions, which may also provide messages to take medication that cannot be stored in the machine (e.g., take medications with food; time to take insulin) based on the individual's needs; and

ii) dispensing medications at the correct time of day in the correct combinations and in the correct quantities;

D) use privacy-protected and secure methods of communication with the participant/authorized representative/assisting party, including:

i) notification when battery is low or unit is jammed, or if the participant has not taken the medication within 90 minutes after the prescribed time;

ii) contact by the unit or support center to the participant/authorized representative/assisting party to assure adherence or needed intervention; and

E) ability to securely transmit information and provide data to the

participant/authorized representative/responsible party, the Department or its designees.

3) The AMD unit must be capable of conducting automatic battery testing and transmitting the results through the AMD unit to the support center on an ongoing basis.

4) If an AMD unit is a Class I medical device, the AMD unit is subject to the General Controls mandated by the Federal Food and Drug Administration, including provisions that relate to adulteration (21 U.S.C.~~USC~~ 351); misbranding (21 U.S.C.~~USC~~ 352); device registration and listing (21 U.S.C.~~USC~~ 360); notification, including repair, replacement, or refund (21 U.S.C.~~USC~~ 360h); records and reports (21 U.S.C.~~USC~~ 360i); and restricted devices (21 U.S.C.~~USC~~ 520(e)). In addition, the manufacturer of the device must fulfill requirements under 21 CFR 820.180 (Record keeping) and 820.198 (Complaint files). If an AMD unit has enhanced features, such as remote capability, it may be classified as a Class II medical device and must then meet applicable Special Controls under the FDA.

5) The AMD unit must have adaptations for operation by participants who have functional, hearing or visual impairments, and language barriers at no extra cost to the participants.

c) Support Center Specifications

1) The AMD support center must have back-up monitoring capacity to take over all medication dispenser notification functions, monitoring and technical support functions.

2) The AMD back-up monitoring center must be at a location different from the primary center, on a different power grid system, and on a different telephone trunk line. It must have a back-up battery and electrical generating capacity, as well as telephone line and wireless/cellular system monitoring abilities. If the back-up center is in the same city as the support center, the AMD provider must provide assurances that back-up can be maintained in the event of a natural disaster.

3) All AMD support center and back-up center equipment, at a minimum, must:

A) monitor the AMD system for the receipt of incoming signals from an installed and programmed AMD unit in a participant's

6767 residence, including missed medication doses, power interruptions
6768 and outages, and test transmissions and fault conditions, on a
6769 continuous basis;
6770
6771 B) direct an appropriate response to the receipt of a signal
6772 immediately via texts/emails to the assisting party and other
6773 designees and call the assisting party and other designees within 90
6774 minutes after missed medications and within eight~~8~~ hours after
6775 power interruptions and outages;
6776
6777 C) provide technical support as required, 24 hours a day, 365 days a
6778 year;
6779
6780 D) identify each participant and simultaneously record all
6781 communication between the participant/authorized
6782 representative/assisting party and the support center, as applicable,
6783 for all signals, including missed medication doses, test
6784 transmissions and fault conditions;
6785
6786 E) display, print and archive the individual identifier, date, time,
6787 communication and response for each signal, test and fault
6788 condition, which must be maintained for at least a three-year~~3-year~~
6789 period of time for quality control and liability purposes;
6790
6791 F) have an uninterruptible power supply~~ (UPS)~~ back-up that will
6792 automatically take over system operation in the event electric
6793 power to the support center is interrupted, other type of
6794 malfunction occurs, or repairs are needed. The back-up power
6795 supply must be sufficient to operate the entire system for a
6796 minimum of seven~~7~~ calendar days;
6797
6798 G) have separate and independent primary and back-up systems,
6799 computer servers, databases, and other components to provide an
6800 uninterruptible monitoring system in the event of equipment
6801 malfunction;
6802
6803 H) perform self-diagnostic testing for malfunctions in the
6804 unit/equipment in a participant's residence and at the support
6805 center, and for fault conditions in the primary and back-up
6806 operating systems and power supply at the support center, that
6807 could interfere with receiving and responding to signals, such as
6808 non-operational AMD units, messages sent from the AMD unit to
6809 the participant/authorized representative/assisting party or

6810 designees without confirmation of receipt, telephone line outages,
6811 power loss, etc.;
6812
6813 I) capability to centrally generate medication compliance data and
6814 reports as requested by the Department;
6815
6816 J) have quality management systems that include tracking and
6817 trending of data, response times and dispositions; and
6818
6819 K) maintain appropriate certification by the FCC under 47 CFR 15
6820 and 68, if applicable.
6821
6822 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
6823
6824 **Section 240.1544 Administrative Requirements for Automated Medication Dispenser**
6825 **Service Providers**
6826
6827 a) In order to qualify for certification, an Automated Medication Dispenser (AMD)
6828 provider must, to the satisfaction of the Department, meet and comply with all
6829 applicable rules, including but not limited to:
6830
6831 1) meet the administrative requirements and minimum administrative
6832 standards under Sections 240.1505 and 240.1510;
6833
6834 2) meet the applicable responsibilities imposed on provider agencies ~~under~~
6835 ~~the Community Care Program (CCP)~~ set forth in Section 240.1520;
6836
6837 3) meet the certification requirements under Sections 240.1600 or 240.1605;
6838
6839 4) provide assurance that its equipment and support center are in continual
6840 compliance with the business and technology requirements imposed on
6841 provider agencies under Section 240.1543;
6842
6843 5) provide assurance that its business operations comply with the service,
6844 staffing and training requirements under Section 240.237;
6845
6846 6) attend and complete management training provided by the Department or
6847 its designee:
6848
6849 A) Training shall be attended and completed by management staff
6850 (e.g., managers, supervisors, billing agents) of the AMD provider
6851 prior to the award of a CCP AMD contract from the Department;
6852

6853 B) At a minimum, the individual responsible for administration of the
6854 CCP AMD program at the provider agency shall attend and
6855 complete this training;
6856
6857 C) The Department is authorized to charge a reasonable fee for this
6858 training to cover related administrative costs;
6859
6860 7) accept all correspondence from the Department and maintain adequate
6861 records for administration, audit, budgeting, evaluation, operation and
6862 planning efforts by the Department in offering the AMD service through
6863 the CCP, which shall include, but are not limited to:
6864
6865 A) records of all referrals, including the disposition of each referral;
6866
6867 B) participant records, which shall include, but are not limited to:
6868
6869 i) applicable forms required by the Department;
6870
6871 ii) dates and times of all AMD notifications and
6872 communications with the participant/authorized
6873 representative/assisting party or designees;
6874
6875 iii) disposition of all participant/authorized
6876 representative/assisting party or designees communications;
6877
6878 iv) dates and times of all equipment tests and system
6879 interruptions; and
6880
6881 C) administrative records, including but not limited to:
6882
6883 i) service statistics;
6884
6885 ii) complaint resolution;
6886
6887 iii) billing and payment information plus the underlying
6888 documentation to support the units of service submitted to
6889 the Department for reimbursement; and
6890
6891 8) comply with all applicable federal, State and local laws, regulations, rules,
6892 service standards and policies or procedures pertaining to the AMD
6893 provider in its business operations and to the services provided under the
6894 CCP.
6895

6896 b) If an AMD provider is not able to meet these administrative requirements, the
6897 Department shall deny its request for a certification of qualifications under
6898 Section 240.1600.
6899
6900 c) All employees of an AMD provider must complete two hours of dementia training
6901 within 30 days of the start of their employment and every calendar year thereafter.
6902 This training must include the following subjects: Alzheimer's Dementia and
6903 Related Disorders; Safety Risks; and Communication and Behavior.
6904
6905 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
6906
6907 **Section 240.1550 Standard Requirements for Adult Day Service Providers**
6908
6909 a) An adult day service provider shall have on file and utilize written procedures to
6910 manage storage and administration of medications, including:
6911
6912 1) storing and locking medications;
6913
6914 2) labeling medications brought to the adult day service provider's site; and
6915
6916 3) ensuring that:
6917
6918 A) prescribed medication is administered by an appropriately licensed
6919 professional to those adult day service participants who are
6920 determined to be unable to self-administer medications;
6921
6922 B) judgment of a participant's inability to self-administer medications
6923 shall be documented by a physician's order or the CCU person-
6924 centered plan of care and/or the adult day service person-centered
6925 plan of care addendum by the program nurse;
6926
6927 C) administration of all medications administered by the adult day
6928 service provider staff (prescription and non-prescription) are
6929 recorded in the participant's case record; and
6930
6931 D) physician orders for medication are utilized and filed in the
6932 participant's case record.
6933
6934 b) A facility that houses an adult day service program (including satellite sites) shall
6935 meet the following criteria:
6936
6937 1) A location will have a home and community-based setting that allows for
6938 services to be provided in the most integrated setting appropriate for each

6939 participant without having the effect of isolating any participant from the
6940 broader community. (See 42 CFR 441.301(c)(5)(v) and 42 CFR
6941 441.301(c)(4)(i).)
6942
6943 A) An integrated setting will:
6944
6945 i) ensure a participant's rights of privacy, dignity and respect
6946 and freedom from coercion and restraint;
6947
6948 ii) optimize, but not regiment, participant initiative, autonomy,
6949 and independence in making life choices, including daily
6950 activities, physical environment, and with whom to interact
6951 (See 42 CFR 441.301(c)(4)(iv)); and
6952
6953 iii) facilitate participant choice regarding services and
6954 supports, and who provides them.
6955
6956 B) A location is not presumed to be a home and community-based
6957 setting if set in a publicly or private-owned facility providing
6958 inpatient treatment; on the grounds of, or adjacent to, a public
6959 institution; or with the effect of isolating participants from the
6960 broader community of individuals not receiving Medicaid Waiver
6961 services, as determined by the federal Centers for Medicare and
6962 Medicaid Services on a case-by-case basis.
6963
6964 2) There shall be a minimum of 40 square feet of activity area per participant.
6965 (Multiple-use areas must be pro-rated on both time and participant basis.)
6966 The activity area in the square feet per participant requirement is exclusive
6967 of exit passages and fire escapes, administrative space, storage areas,
6968 bathrooms, kitchen used for meal preparation, space required for
6969 equipment and gymnasiums or other areas when used exclusively for
6970 active sports.
6971
6972 3) All adult day service providers shall comply with the applicable provisions
6973 of the following codes and standards.
6974
6975 A) State of Illinois Codes and Standards
6976

	Code or Standard	**Agency**
i)	Ill. Plumbing Code (77 Ill. Adm. Code 890)	Department of Public Health or its authorized local designee

ii)	Illinois Accessibility Code (71 Ill. Adm. Code 400) Environmental Barriers Act [410 ILCS 25]	Capital Development Board offers guidance to design professionals and building code officials regarding the interpretation and application of the Illinois Accessibility Code NOTE: It shall be incumbent upon the provider to assure that its facility meets all applicable requirements as promulgated by the Capital Development Board. (No written documentation shall be required.)
iii)	Fire Prevention and Safety (41 Ill. Adm. Code 100)	Office of State Fire Marshal
iv)	Illinois Vehicle Code [625 ILCS 5]	Secretary of State of Illinois
v)	Food Service Sanitation (77 Ill. Adm. Code 750)	Department of Public Health or its authorized local designee

6977
6978 B) Other Codes and References
6979

	Code or Standard	**Agency**
i)	National Fire Protection Association, 1 Batterymarch Park, Quincy MA 02169-7471 (NFPA 101 Life Safety Code: Chapters 16 and 17; 2018 edition; this incorporation includes no later editions or amendments)	National Fire Protection Association and Office of State Fire Marshal shall inspect
ii)	Americans With Disabilities Act (42	

U.S.C.~~USC~~ 12101 et seq.)

C) In addition to compliance with the standards set forth in this subsection (b)(3), all applicable local and State building, fire, health and safety codes, ordinances and regulations that are enforced by city, county or other local jurisdictions in which the facility is, or will be, located must be observed and documented through required inspections by appropriate officials.

4) Each facility shall have posted an emergency plan for evacuation and shall conduct quarterly fire drills in accordance with subsection (b)(3)(B)(i). Written documentation of the dates of the quarterly fire drills must be on file at the facility. A diagram of emergency evacuation routes shall be posted, at a minimum, in all corridors and common areas. All personnel employed on the premises shall be aware of the routes.

5) Each facility shall maintain room temperatures in the facility of not less than 70 degrees Fahrenheit and not more than 85 degrees Fahrenheit by utilizing heating system/air conditioning/circulating fans.

6) Each facility shall designate a dining area (equipped with enough chairs and table space) to accommodate the daily number of participants.

7) Each facility shall have and maintain in working order during operating hours at least one~~1~~ bathroom facility that is physically accessible to persons with disabilities for up to 12 participants and a minimum of 2 bathroom facilities (one~~1~~ accessible to persons with disabilities) to serve 13 or more participants.

8) Each facility shall have locked space for storage of office equipment, chemicals/cleaning products and other hazardous supplies.

9) Hot water temperatures shall be controlled to not exceed 119 degrees, but shall not be less than 100 degrees, Fahrenheit in all locations where participants have access to dispensing hot water, including bathroom facilities through appropriate plumbing mechanisms (e.g., anti-scald devices, pumps, and/or hot water tank thermostat settings). Hot water temperatures at all locations within the ADS shall be checked weekly and a written log shall be securely kept in the main administrative office.

10) Unsupervised participants shall not be allowed in the kitchen if water temperatures are not controlled as required in subsection (b)(9).

Participants should not be allowed in areas where supplies/medications are stored or where a microwave is in use unless supervised.

11) Each facility shall have at least one~~1~~ quiet place equipped with a reclining chair, cot or bed where a participant may rest.

12) Exit areas shall be clear of equipment and debris at all times and shall be equipped with monitoring or signaling devices to alert staff to participants leaving the facility unattended.

13) One landline telephone capable of accessing and being located by a 911 emergency response system, if available in the area, shall be immediately available within the activity area for participants. A list of emergency numbers shall be posted by the telephone.

14) Supplies and equipment for emergency first aid shall be immediately accessible to activity areas for participants.

c) An adult day service provider (including each satellite site) shall meet the following criteria relative to meals provided to participants (prepared on-site or contractual):

1) The adult day service provider shall provide to each participant one~~1~~ meal at mid-day that meets the Dietary Guidelines for Americans, 2015-2020, 8th edition, published by the Secretary of Health and Human Services and the Secretary of Agriculture; and provide each participant a minimum of 33½ percent of the Dietary Reference Intakes (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Supplementary nutritious snacks shall also be provided. The adult day service provider shall provide modified diets as directed by the participant's physician.

2) Adult day service providers (whether meals are prepared on-site or contractually) shall:

A) Have menus approved and so documented by the registered dietitian. Menus shall reflect portion sizes as appropriate.

B) Post menus in advance in a location visible to the participants within the adult day service facility.

C) Assure that menus are planned for a minimum of four~~4~~ weeks on a menu form.

7064
7065 D) Develop methods and follow written procedures to control portion
7066 sizes and to meet the one-third daily dietary reference intakes
7067 recommended.
7068
7069 E) One employee at each adult day service site, either
7070 handling/preparing or supervising the handling/preparing of foods,
7071 shall meet DPH Food Service Sanitation rules (77 Ill. Adm. Code
7072 750).
7073
7074 F) Have on file and follow written procedures for receiving and
7075 storing food that must include:
7076
7077 i) verification of food quantities;
7078
7079 ii) checking and documentation of food temperatures at time
7080 of delivery and serving;
7081
7082 iii) equipment to be utilized;
7083
7084 iv) procedures to follow for foods that arrive above or below
7085 temperature, deteriorated food and food shortages.
7086
7087 G) Ensure that catered meals are transported in equipment that
7088 maintains temperatures of hot food at 140 degrees Fahrenheit, or
7089 above, and cold foods at 41 degrees Fahrenheit, or below. Foods
7090 shall be maintained and served at the above temperatures at the
7091 adult day service site.
7092
7093 H) Ensure that potentially hazardous foods (i.e., food that consists in
7094 whole or in part of milk, milk products, eggs, meat, poultry, fish,
7095 shellfish or other ingredients, including synthetic ingredients, in a
7096 form capable of supporting rapid and progressive growth of
7097 infectious or toxigenic microorganisms) intended to be served cold
7098 shall be pre-chilled and transported/maintained at a temperature of
7099 41 degrees Fahrenheit, or below. Potentially hazardous food
7100 intended to be served hot shall be transported/maintained at a
7101 temperature of 140 degrees Fahrenheit, or above.
7102
7103 I) Ensure that potentially hazardous foods prepared on-site shall be
7104 prepared in accordance with required cooking temperatures as
7105 specified by 77 Ill. Adm. Code 750 and maintained until service at
7106 140 degrees Fahrenheit, or above, for hot foods and 41 degrees

7107 Fahrenheit, or below, for cold foods.
7108
7109 J) If food is prepared by a caterer, the adult day service provider shall
7110 keep a copy of the current caterer's inspection certificates/letters on
7111 file to verify that the operation complies with all health, safety and
7112 sanitation regulations.
7113
7114 d) An adult day service provider (including each satellite site) shall comply with
7115 applicable requirements of the current Illinois Vehicle Code [625 ILCS 5] and
7116 meet the following criteria relative to transportation provided to participant's
7117 (directly or contractually):
7118
7119 1) Adult day service provider vehicles that transport participants shall be
7120 equipped with a working two-way~~2-way~~ communications device and
7121 written procedures to be followed in the event of an emergency.
7122
7123 2) An adult day service provider that uses its own vehicles to transport
7124 participants shall have on file and utilize written procedures to ensure, to
7125 the extent possible, that safe transportation is provided.
7126
7127 3) An adult day service provider that subcontracts with another entity to
7128 transport participants shall have on file and incorporate written procedures
7129 in the service agreement to ensure, to the extent possible, that safe
7130 transportation is provided.
7131
7132 e) Adult day service providers shall acquire and have on file an emergency contact
7133 and a recent photograph of each participant for emergency purposes.
7134
7135 f) An adult day service provider shall provide services to all participants in the CCP
7136 referred by the CCU, except:
7137
7138 1) participants who do not meet the adult day service provider's admission
7139 criteria; and
7140
7141 2) participants whose condition warrants discharge under the adult day
7142 service provider's discharge criteria.
7143
7144 g) It is the adult day service provider's responsibility to advise the primary
7145 caregiver, the participant's care coordinator and/or appropriate professional of
7146 any changes in the participant's health or functional ability.
7147
7148 h) Management staff of the adult day service provider shall be required to complete
7149 adult day service management training.

1) Training shall be completed by the provider prior to the award of a CCP adult day service contract from the Department.

2) At a minimum, the provider Program Administrator, or Program Coordinator/Director if also functioning as the Program Administrator, shall complete this training.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1555 General Adult Day Service Staffing Requirements

a) A separate and identifiable staff must be designated for sole use by the adult day service program.

b) Each adult day service provider shall have at the adult day service site adequate personnel in number and skill to comply with subsection (c) ~~of this Section~~ and Section 240.1520(f) and to provide for:

1) program and fiscal administration;

2) nursing and personal care services;

3) nutritional services;

4) planned therapeutic/recreational activities;

5) obtaining prompt services of emergency personnel and hospitalization, if needed;

6) immediately notifying the participant's authorized representative or family member of any illness, accident or injury to the participant;

7) provision/arrangement of transportation services to and from the adult day service site;

8) record keeping;

9) development, implementation and semi-annual review of individualized person-centered plans of care;

10) program evaluation and marketing;

7193 11) supervision and evaluation of staff;
7194
7195 12) monitoring and meeting staff training needs; and
7196
7197 13) maintenance of a clean and safe physical environment.
7198
7199 c) The minimum ratio of full-time staff (qualified adult day service staff, trained
7200 volunteers or substitutes) or full-time equivalent (FTE) staff present at the adult
7201 day service site to participants, when participants are in attendance, shall be:
7202

Staff	Participants
2	1 to 12
3	13 to 20
4	21 to 28
5	29 to 35
6	36 to 45

7203
7204 1) Add one1 additional staff person for each seven7 additional participants.
7205
7206 2) Fifty percent or more of a staff member's time shall be spent in on-site
7207 direct service or supervision on behalf of one1 or more participants in
7208 order to be considered in the ratio.
7209
7210 3) Staff included in the staff-participant ratio shall include only those who
7211 work on site, are actively involved with the participants, and are
7212 immediately available in the activity area, except for during client drop-off
7213 and pick-up times in normal business hours, to meet the participants'
7214 needs.
7215
7216 d) Each adult day direct service contact employee shall have:
7217
7218 1) Pre-service Training
7219 Pre-service training totaling a minimum of 2624 hours training within the
7220 first week of employment (exclusive of orientation). Two of those hours
7221 shall be mandatory dementia training which include shall include subjects
7222 related to Alzheimer's Dementia and Related Disorders; Safety risks; and
7223 Communication and behavior. A worker may be exempted from pre-
7224 service training, but not dementia training, by the provider if the worker
7225 has had previous documented training equivalent to 24 hours, with another
7226 CCP agency, or in a related field, within the past two2 years prior to this
7227 employment or is anholds a valid, active CNA or CMA or holds a valid,
7228 RN or LPN license, and/or a BA, BS, BSW or higher degree. AtPre-
7229 service training shall include at least 18 hours of the remaining training

7230 selected from the following topics:
7231
7232 A) Purpose and goals of adult day service;
7233
7234 B) Facility, environmental and safety considerations;
7235
7236 C) Assistance with activities of daily living;
7237
7238 D) Basic principles of personal care;
7239
7240 E) Dealing with adverse behaviors: wandering, aggression, mental
7241 illness and depression;
7242
7243 F) Promoting participant dignity, independence, self-determination,
7244 privacy, choice and rights;
7245
7246 G) Understanding aging and functionally-impaired persons;
7247
7248 H) Recognizing participant abuse, neglect and/or exploitation; abuse
7249 and neglect prevention and reporting requirements;
7250
7251 I) Confidentiality of participant information;
7252
7253 J) Communication/interaction skills;
7254
7255 K) Universal precautions, blood-borne pathogens and infection
7256 control;
7257
7258 L) Fire and life safety, including emergency procedures to be
7259 implemented under the agency's all hazards disaster operations
7260 plan;
7261
7262 M) Family dynamics;
7263
7264 ~~N) Understanding Alzheimer's Disease and dementia;~~
7265
7266 N~~O~~) Body mechanics and normal range of motion, transfer techniques
7267 and positioning;
7268
7269 O~~P~~) Cultural diversity;
7270
7271 P~~Q~~) Recognizing changes in bodily functions that should be reported to
7272 the supervisor;

Q~~R~~) Nutrition and safe food handling;

R~~S~~) CPR and first aid;

S~~T~~) Participant activities;

T~~U~~) Respiratory services;

U~~V~~) Use of seclusion and restraint.

2) In-service Training

A minimum of 14~~12~~ hours of in-service training for continuing education per year shall be mandatory for all adult day service employees. Pre-service training received under subsection (d)(1) shall fulfill the continuing education requirement for new employees for the first year. Two of those hours shall be mandatory dementia training which include shall include subjects related to Alzheimer's Dementia and Related Disorders; Safety Risks; and Communication and Behavior. At~~In-service training shall include at~~ least the remaining nine~~9~~ hours of training selected from among the following topics:

A) Responding to emergency situations, including, but not limited to, site-related emergencies (e.g., late pick-up of participants), participant-related emergencies (e.g., participants leaving the site unattended), choking prevention and intervention techniques;

B) Appropriate and safe techniques in performing and assisting with personal care;

C) Developing and improving participant centered activities;

D) Modification of the environment to support engagement/well-being;

E) Promoting participant dignity, independence, self-determination, privacy, choice and rights;

F) Special characteristics of the elderly population; physical, emotional and developmental needs of the participant;

G) Recognizing participant abuse, neglect and/or exploitation; abuse and neglect prevention and reporting requirements;

H) Confidentiality of participant information;

I) Communication skills;

J) Universal precautions, blood-borne pathogens and infection control;

K) Fire and life safety, including emergency procedures to be implemented under the agency's all hazards disaster operations plan;

L) Dealing with adverse behaviors, e.g., mental illness, depression, aggression and wandering;

M) Family dynamics;

~~N) Diseases of the elderly; understanding Alzheimer's Disease and dementia;~~

N~~O~~) Body mechanics and normal range of motion, transfer techniques and positioning;

O~~P~~) Chronic illness, death and dying;

P~~Q~~) Medicaid fraud and abuse;

Q~~R~~) Cultural diversity;

R~~S~~) Recognizing changes in bodily functions that should be reported to the supervisor;

S~~T~~) CPR and first aid;

T~~U~~) Understanding advance directives;

U~~V~~) Nutrition and safe food handling;

V~~W~~) Respiratory services;

W~~X~~) Use of seclusion and restraint.

3) Progress toward certification in a related field (e.g., CNA) may be used for up to three~~3~~ hours of in-service training per calendar year.

4) All provider employees not in receipt of Department training certificates must complete two hours of dementia training within 30 days of the start of their employment and every calendar year thereafter. This training must include the following subjects: Alzheimer's Dementia and Related Disorders; Safety Risks; and Communication and Behavior.

e) At least two~~2~~ program adult day service staff shall be certified in CPR and trained in first aid, and at least one~~1~~ trained staff shall be on-site when participants are present.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1560 Adult Day Service Staff

a) The following staff qualifications shall be required throughout the term of the contract of all adult day service providers (with specified exceptions):

1) An Adult Day Service Program Administrator shall:

A) Meet the following qualifications:

i) have a bachelor's degree in a health or human services or related field (including social or health sciences, public administration or physical education) or be a Registered Nurse or Health Services Administrator; or

ii) demonstrate two~~2~~ years of progressively responsible supervisory experience in a program serving the elderly for each year of education being replaced (up to 4) in the disciplines defined in subsection (a)(1)(A)(i).

B) The responsibilities of the Administrator may be performed by the Program Coordinator/Director. If the Administrator's function is also performed by the Program Coordinator/Director, only the qualification requirements for Program Coordinator/Director apply.

2) An Adult Day Service Program Coordinator/Director shall:

A) Meet the following qualifications:

i) have a bachelor's degree in health or human services, social or health sciences, physical education, or related field;

ii) be a Registered Nurse; or

iii) demonstrate two~~2~~ years of progressively responsible supervisory experience in a program serving the elderly for each year of education being replaced (up to four~~4~~) in the disciplines defined in subsection (a)(2)(A)(i).

B) Be on duty full time when participants are in attendance or have a qualified substitute (meets or exceeds the qualifications set out in subsection (a)(2)(A)(i) through (iii)).

3) A program nurse shall be:

A) ~~be~~ a RN or LPN under the supervision of a RN (RN may be contractual and must meet with the LPN at least monthly to review person-centered plans of care and medication administration records, and be available to provide direction as needed);~~:~~

~~i) Registered Nurse (RN) licensed by the State of Illinois; or~~

~~ii) Licensed Practical Nurse (LPN) licensed by the State of Illinois under the supervision of an RN (RN may be contractual and must meet with the LPN at least monthly to review person-centered plans of care and medication administration records, and be available to provide direction as needed);~~

B) ~~be~~ on duty at least one-half of a full-time (FTE) work period each day when participants are in attendance, either as staff or on a contractual basis; and

C) ~~be~~ full time, if also serving as the Program Administrator or Program Coordinator/Director, and shall meet the qualifications for a program nurse and fulfill responsibilities for all assigned positions.

4) A transportation Driver/Escort (provider employed or contractual) for those adult day service providers who provide the transportation service component shall:

A) meet all applicable requirements of the Illinois Vehicle Code [625 ILCS 5];

B) be certified in CPR and trained in first aid; and

C) have the appropriate driver's license or endorsements based upon the size and type of the vehicle being driven.

5) Nutrition Staff:

A) Nutrition staff (provider employed or contractual) shall include:

i) at least one~~1~~ staff person who meets the requirements of the Food Service Sanitation Code (77 Ill. Adm. Code 750).

ii) a Nutrition Consultant/Dietitian, either paid or in-kind, who shall be licensed by the Department of Financial and Professional Regulation with experience in an agency setting and who shall approve menus for adult day service providers to meet requirements stated in subsection (a)(5)(B).

B) The nutrition staff is responsible for providing daily meals meeting requirements specified in Section 240.230(a)(5).

b) The following optional staff, either contractual or employed by an adult day service provider, shall meet the specified qualifications:

1) A social service worker shall:

A) be under the direction of the Program Coordinator/Director;

B) possess a Bachelor's degree in Social Work or a related field and have at least one~~1~~ year's work experience, preferably with programs for the elderly and disabled; and

C) if the social service worker function is performed by the Program Administrator or Program Coordinator/Director, that person must be full time, and must meet the qualifications for a social worker and fulfill responsibilities for all assigned positions.

2) Program assistants shall have a high school diploma or general education

7487 diploma, or two~~2~~ years of prior documented experience working in
7488 programs for the elderly, or demonstrate continued progress towards
7489 meeting the educational requirement of a general education diploma by
7490 current registration and evidence of successful completion of course work.
7491
7492 3) A medical consultant shall be a physician with an active license~~licensed to~~
7493 ~~practice medicine by the State of Illinois~~.
7494
7495 4) A rehabilitation consultant shall be licensed, registered or certified by the
7496 Department of Financial and Professional Regulation in a discipline that
7497 relates to rehabilitation.
7498
7499 c) The following requirements shall apply to substitutes for staff positions and/or
7500 regularly scheduled volunteers/students/student interns utilized by an adult day
7501 service provider:
7502
7503 1) the adult day service provider shall have on file information documenting
7504 the same personal, health, administrative and professional qualifications
7505 for substitutes as are required of staff for whom they act as substitutes;
7506
7507 2) persons agreeing to be available as substitutes or for use in emergencies
7508 shall sign a written statement kept on file at the adult day service site,
7509 certifying to their availability and agreement to serve in the particular
7510 capacity. The file of each person serving in this capacity shall contain
7511 such a statement for each calendar year of availability;
7512
7513 3) volunteers/students/student interns shall complete an application
7514 indicating their reason for participation in the program and special skills;
7515
7516 4) volunteers/students/student interns may serve in any capacity for which
7517 they are qualified (refer to subsection (c)(1));
7518
7519 5) substitutes and volunteers/students/student interns shall be supervised by
7520 the staff person supervising the function to which the volunteer or
7521 substitute is assigned;
7522
7523 6) substitutes and volunteers/students/student interns who are not used to
7524 meet program requirements are exempt from pre-service and in-service
7525 training requirements.
7526
7527 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
7528
7529 **Section 240.1570 Service Availability Expansion**

7530
7531 a) A CCP participant may be allowed access to CCP ADSadult day services in a
7532 service area in which the participant does not reside (outlying service area) under
7533 the following circumstances:
7534
7535 1) the CCU has determined the needs of the participant may best be served
7536 by a provider in an outlying service area;
7537
7538 2) either:
7539
7540 A) the geographic area in which the participant resides does not have
7541 a provider of the needed services; or
7542
7543 B) the participant may be provided services more
7544 conveniently/appropriately by a CCP provider in an outlying
7545 service area for the following reasons:
7546
7547 i) the authorized CCP providers in the participant's service
7548 area have reached the maximum capacity and have
7549 approval to not accept new participants and/or is unable to
7550 provide a service without delay and/or interruption;
7551
7552 ii) optional service components required by the participant are
7553 unavailable from the CCP authorized provider in the
7554 participant's service area but are available from a CCP
7555 authorized provider in another service area;
7556
7557 iii) transportation can be more conveniently arranged to a CCP
7558 authorized provider in another service area (adult day
7559 service only); or
7560
7561 iv) special needs of the participant (e.g., language-appropriate
7562 workers) can only be met by a CCP authorized provider in
7563 another service area; and
7564
7565 3) The CCP authorized provider in the outlying service area agrees to
7566 provide the service required without delay/interruptions to the referred
7567 participant.
7568
7569 b) A CCP in-home care participant may be allowed access to CCP in-home care
7570 services in a service area in which the participant does not reside (outlying service
7571 area) upon receipt of written approval to the CCU from the Department under the
7572 following circumstances:

7573
7574 1) The CCU has determined that the special needs of the participant (e.g., language specific workers) can only be met by a CCP authorized provider in another service area; and
7575
7576
7577
7578 2) The CCP authorized provider in the outlying area agrees to provide the service required without delays/interruptions to the referred participant; and
7579
7580
7581
7582 3) The CCP authorized providers in the participant's area of residence are unable to meet the special needs of the participant without delays/interruptions.
7583
7584
7585
7586 c) A request by a participant to receive CCP services from a provider in an outlying service area is inappropriate if the participant refuses to accept CCP services deemed appropriate by the CCU in the participant's service area. In this instance, service will be denied or terminated as appropriate.
7587
7588
7589
7590
7591 d) If a provider's contract period is extended in writing by the Department, approval of the service availability expansion is also extended for the same effective period.
7592
7593
7594
7595 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
7596
7597 **Section 240.1575 Adult Day Service Site Relocation**
7598
7599 Any CCP adult day service provider intending to relocate its primary or satellite site shall obtain written approval of the new facility from the Department.
7600
7601
7602 a) For all reasons for relocation except an emergency:
7603
7604 1) the provider shall file a letter of intent to relocate, providing detailed information including the reason for the relocation, the proposed relocation site and assurance that requirements specified in subsections (a)(2)(A) and (a)(2)(B) are met.
7605
7606
7607
7608
7609 2) the letter of intent to relocate shall be received by the Department at least 30 calendar days prior to the anticipated date of the proposed relocation.
7610
7611
7612 A) The proposed facility shall meet all CCP standards, and federal, State and local codes, as set forth in Section 240.1550.
7613
7614
7615 B) The provider shall assure the Department that service to the

provider's CCP participants will be uninterrupted.

C) A request for a contract amendment may be made by the provider if the relocation affects the designated address to which the Department mails its correspondence, etc., to the provider.

3) upon receipt and approval of the letter of intent to relocate, the Department shall issue a temporary authorization to provide service in the new location.

4) final approval of the relocation shall be based upon on-site review of the facility by the Department (see Section 240.1550).

b) When any emergency requires relocation of an ADS~~adult day service~~ site the provider shall immediately notify the Department.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1580 Standards for Alternative Providers

a) In the event that CCP services are not provided to an eligible participant within the time limit specified in Section 240.910, the eligible participant may arrange to receive CCP in-home services from an individual ~~or a home care agency~~ of the eligible participant's choice 15 calendar days after the date of the notice of eligibility. The CCU and Department shall approve the participant's choice of individual prior to initiation of services.~~or home care agency for in-home services to be provided.~~

~~b) If there is an interruption of services provided to a participant due to the failure of a contractual provider to provide those services, the CCU shall assist the participant in locating an individual or home care agency.~~

~~c) The Department shall authorize the individual or home care agency and shall guarantee a minimum of 15 calendar days of service provided by the alternative provider, if at the request of the alternative provider. A home care agency whose previously held CCP contract was terminated for cause shall not be authorized as an alternative provider.~~

b~~d~~) The contractual provider shall pay the alternative provider at its usual and customary rate of pay.~~The Department shall make payment on a monthly basis for the services at the rate that would have been paid an individual provider, if an individual is selected by the eligible participant; or at the usual and customary rate of the home care agency/provider chosen by the eligible participant to provide this~~

~~service, if a home care agency is selected by the eligible participant.~~

c~~e~~) The contractual provider may terminate the alternative provider if the contractual provider has a person who can provide the services in accordance with the person centered plan of care.~~Payment shall continue in accordance with subsection (c), and only until the Department's contractual provider initiates provision of CCP services to the participant, at which time service by the alternative provider shall be immediately terminated. The CCU shall verbally notify the alternative provider and the participant of the date upon which service shall be initiated by the Department's contractual provider.~~

~~f) Request for payment for services rendered by an individual alternative provider shall be submitted to the Department by the individual providing the service.~~

~~g) Payment for services rendered by a home care agency of the eligible participant's choice shall be made by the Department following submittal by the agency and processing by the Department of billing forms provided to the agency by the Department.~~

~~h) Payment shall be authorized in compliance with the State Prompt Payments Act [30 ILCS 540].~~

~~i) The Department shall be liable for its share of the cost of CCP services, as determined in accordance with Sections 240.855 and 240.870.~~

~~j) The payment for the monthly expense for care incurred by the participant for CCP alternative provider services shall be the responsibility of the participant as set forth in Section 240.875.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

SUBPART P: PROVIDER PROCUREMENT

Section 240.1600 Provider Agency Certification

a) All services provided to CCP participants shall be delivered in accordance with Provider Agreements entered into between certified provider agencies and the Department.

b) For purposes of administrative efficiency, the Department may initiate the provider certification process for the CCP by a specific service, on a geographic basis, or in accordance with other criteria determined by the Department.

c) Initial Certification

Any willing and qualified provider agency (see the federal Medicaid waiver, this Part and 42 CFR 431.51 (2008)) interested in the opportunity to enter into a Provider Agreement with the Department for the provision of CCP services shall comply with the following certification procedures:

1) A provider agency requesting initial certification of qualifications shall submit, in a form and manner prescribed by the Department, material documenting the ability to comply with administrative requirements, service specifications and any other administrative or operational information required by the Department for the applicable service.

A) The Department or its designee will review the material submitted and, if necessary, will request additional information. The Department or its designee will conduct on-site reviews of a prospective provider agency for in-home service and adult day service under the CCP unless a performance review of the provider agency has already been completed by the Department or its designee within the prior 12 months. The Department reserves the right to conduct on-site reviews of a prospective provider agency for emergency home response service and AMD service under the CCP. Failure of a prospective provider to respond to the Department's request for a site-visit may result in the denial of certification.

B) If additional information is requested by the Department, the provider agency has 30 calendar days after the date of request to submit this information.

C) After 60 calendar days, the provider agency's request for certification of qualifications will be closed and all information must be resubmitted to the Department if the provider agency wants to continue to request certification.

2) Provider agencies will be notified in writing of the results of the certification request. Those provider agencies determined by the Department to be qualified will be certified for a period of no more than 3 years and afforded the opportunity to execute a Provider Agreement (generally for a three-year~~3-year~~ period) for the applicable service.

d) Recertification

The Department, or its designee, shall conduct recertification of each provider agency with a valid Provider Agreement no less frequently than every three~~3~~

years to determine continued compliance with qualifications for the applicable service. The timing of recertification shall be based upon the timing of the initial certification (see subsection (b)) or of the most recent recertification.

1) The Department, or its designee, shall notify each provider agency, in writing, at least 30 calendar days prior to recertification to request the material required for the recertification. Any provider agency interested in renewing its Provider Agreement shall submit, in a form and manner prescribed by the Department, material documenting the continued ability to comply with the administrative requirements, service specifications, and any other administrative or operational information required by the Department for the applicable service.

2) Before recertifying a service provider, the Department will conduct a performance review under Section 240.1660.

3) Provider agencies will be notified in writing of the results of the recertification.

4) Those provider agencies determined by the Department to be qualified will be recertified for a period of no more than three~~3~~ years and afforded the opportunity to execute renewal of the Provider Agreement (generally for a three-year~~3-year~~ period) for the applicable service.

e) Other initial certification or recertification considerations include, but are not limited to:

1) pending or current Departmental on-notice or contract action for failure to adhere to Provider Agreement requirements, including a history of non-compliance with the Provider Agreement;

2) notification from another governmental entity of similar contract actions or non-compliance findings;

3) financial insolvency, criminal indictment or conviction, or other legal issues that, in the opinion of the Department, would make the award of a Provider Agreement contrary to the best interest of the State;

4) complaints forwarded to the Department by the Attorney General's office, the Better Business Bureau or other consumer protection organizations; or

5) the current provider agency is not in good standing with the Department.

f) The Department may require completion of additional disclosure statements and/or background inquiries if there is reason to believe offenses have occurred since completion of previous disclosures and background inquiries.

g) The Director shall represent and act for the State in all matters pertaining to the Application for Certification process and Provider Agreements awarded. The Director receives all recommendations and has the ultimate decision making authority for issuing Provider Agreements. The Director reserves the right to allow the applicant to correct inadvertent, technical errors in the application when, in the Director's opinion, the best interest of the State will be served by the correction.

h) Any provider agency denied initial certification of qualifications or recertification for the provision of CCP services shall be afforded the opportunity to submit another request to the Department after a 60-day period of time after issuance of the determination or notification of a final decision or other action on an objection filed pursuant to Section 240.1645. The provider agency may also object to the decision in a form and manner prescribed by the Department in the written notification of denial (see Section 240.1645).

i) Provider Agreements will be entered with qualified provider agencies on a schedule determined by the Department, but no more frequently than semiannually after initial certification.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1605 Emergency Certification

a) The Department shall obtain CCP services through any means of selection likely to result in provider certification and subsequent issuance of a Provider Agreement under the following circumstances:

1) service is immediately needed to prevent interruption of services to current participants;

2) service is immediately needed to protect a participant's health, safety or welfare;

3) service is of such a nature or the market place is such that only one~~1~~ provider is reasonably capable and willing to perform the requisite services; and/or

4) to establish new or additional services in an area in which the Department

has determined an underserved population exists.

b) The Department shall assure, to the extent possible, through the certification process, that any provider selected under the emergency circumstances included in subsection (a) is qualified to provide CCP services and that the health, safety and welfare of participants are protected.

c) Certification issued under this Section is not renewable. Recertification of the provider must occur under Section 240.1600.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1607 Standard CCP Provider Agreement

a) In order to enter into a CCP Provider Agreement, a provider must first be certified by the Department under Section 240.1600 or 240.1605.

b) A Provider Agreement shall be entered into between the Department and the certified provider agency as evidence of the terms and conditions of the agreement to provide CCP services within the geographic area specified within the Provider Agreement. Except during the transition period referred to in Section 240.1600(b), Provider Agreements generally will be for a period of three~~3~~ years. A Provider Agreement does not guarantee that the provider will be the sole provider of CCP services within the described geographic area.

c) The terms and conditions of the Provider Agreement shall, at a minimum, include the following:

1) the Provider Agreement may be terminated without cause by either party upon 60 calendar days written notice;

2) the Provider Agreement may be amended, with the mutual consent of both parties, at any time during the term of the Agreement; and

3) all program and financial records, reports and related information and documentation, including participant files, that are generated as a result of the Provider Agreement shall be considered the property of the Department.

d) At the time of application for certification and before the Provider Agreement is entered, the provider shall submit documentation specified by the Department to confirm the legal structure under which it is doing business.

7874 1) The Department shall be immediately notified by the provider in the event
7875 of a merger/consolidation/sale of assets of a provider and shall be given
7876 copies of all relevant supporting documents.
7877
7878 A) Following review of the merger/consolidation/sale of assets
7879 documents, the Department will determine whether the
7880 merger/consolidation/sale of assets has resulted in an assignment
7881 of the Provider Agreement (see subsection (k)).
7882
7883 B) If the merger/consolidation/sale of assets has not resulted in an
7884 assignment, the Department retains the right to terminate the
7885 Provider Agreement if performance of the Provider Agreement by
7886 the new corporate structure is not in the best interests of the CCP,
7887 such as a merger or consolidation with an entity that has been
7888 subject to previous contract action by the Department or some
7889 other state or federal agency.
7890
7891 2) Failure to notify the Department shall result in termination of the Provider
7892 Agreement.
7893
7894 e) Upon written notification from the Department of a change in the fixed unit rates
7895 of reimbursement, the provider may exercise its 60 calendar day termination
7896 rights if the provider no longer wishes to provide service at the newly established
7897 fixed unit rates of reimbursement.
7898
7899 f) Providers shall have sufficient personnel to ensure service to all CCP participants.
7900
7901 g) During the term of the Provider Agreement, the provider will maintain its
7902 adherence to the Illinois Act on the Aging, this Part and any requirements and
7903 representations made by the provider during the certification process.
7904
7905 h) Providers may be units of State government, units of local government, for-profit
7906 or not-for-profit corporations, limited liability companies, sole proprietorships or
7907 partnerships.
7908
7909 1) An agency of State government must submit a letter from the head of the
7910 agency citing the statutory authority for the agency to enter into a Provider
7911 Agreement to provide the proposed CCP service.
7912
7913 2) A unit of local government must submit a copy of the resolution or
7914 ordinance duly passed by the governing body of the unit of government
7915 authorizing the execution of the Provider Agreement. The resolution or

ordinance shall designate the individual authorized to execute the Agreement on behalf of that unit of government.

3) A partnership or sole proprietorship must submit copies of the "Certificate of Ownership of Business" issued by the county clerks for the counties in which the provider is proposing to provide CCP service.

4) A corporation or limited liability company must submit a "Certificate of Good Standing" from the Office of the Illinois Secretary of State certifying that the corporation has complied with the requirement to file an annual report and has paid required franchise taxes.

5) A not-for-profit corporation shall submit:

A) a "Certificate of Good Standing" from the Office of the Illinois Secretary of State certifying that the corporation has complied with the requirement to file an annual report; and

B) a current letter from the Office of the Illinois Attorney General certifying that the corporation is in full compliance with or is exempt from the charitable trust laws of the State of Illinois. When renewing a Provider Agreement, a non-exempt provider shall submit to the Department, upon request, a letter certified by the provider's Board of Directors stating that the provider remains in compliance or is exempt.

6) A nongovernmental agency shall certify that it is legally qualified to contract with the State of Illinois.

i) Providers shall certify that they acknowledge and comply with the Illinois Human Rights Act [755 ILCS 5]; the Equal Employment Opportunity Act of 1974, as amended (Title VII of the U.S. Civil Rights Act of 1964, as amended (42 U.S.C.~~USC~~ 2000e et seq.)); the Civil Rights Act of 1964, as amended (42 U.S.C.~~USC~~ 2000d et seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C.~~USC~~ 790 et seq.); and the Immigration Reform and Control Act of 1986 (8 U.S.C.~~USC~~ 1101 et seq.).

j) Providers shall certify to the Department that they are fiscally sound, as defined in Section 240.160 and further provided in Section 240.1505(a)(10 and 11).

k) Assignment by a provider of a Provider Agreement to any other organizations or entities is not allowed. Any succeeding provider must be certified as a CCP

7958 provider under this Part and must enter into a new Provider Agreement with the
7959 Department.
7960
7961 l) Failure by providers to seek and obtain written Department approval prior to
7962 entering into subcontracts with other entities for the provision of CCP services
7963 shall result in the immediate termination of the Provider Agreement.
7964
7965 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
7966
7967 **Section 240.1615 Provider Initiated Service Area Modifications**
7968
7969 a) To request approval to modify a service area, a certified provider agency must
7970 submit in writing to the Department a plan of the proposed expansion or
7971 reduction, reasons with supportive information for the modification, and the
7972 revised boundaries of the agency's original service area.
7973
7974 b) The Department may approve or deny requests for service area modification
7975 based upon one~~1~~ or more of the following reasons:
7976
7977 1) demonstrated ability or inability to comply with standards as illustrated by
7978 substantiated complaint history, review reports or prior contract actions;
7979
7980 2) evidence of ability or inability to manage and supervise services
7981 throughout the current service area;
7982
7983 3) continuity or disruption of participant care;
7984
7985 4) assurance of, or failure to assure, participant freedom of choice; or
7986
7987 5) action in, or failure to act in, the best interest of the participant or the CCP.
7988
7989 c) If the Department approves the service area modification, the Provider Agreement
7990 shall be amended to include the modified service area.
7991
7992 d) An agency shall provide a minimum of 60 days notice to the Department prior to
7993 the proposed effective date of a service area reduction.
7994
7995 e) A provider who has been granted a provisional contract is not eligible for a
7996 service area expansion.
7997
7998 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
7999
8000 **Section 240.1645 Objection to Certification Decision**

8001
8002 a) A provider may file an objection, in limited circumstances, if a certification
8003 request is denied by the Department.
8004
8005 b) Examples of circumstances that do not constitute an appealable basis for objection
8006 include:
8007
8008 1) timing of initiation of certification process by the Department;
8009
8010 2) termination of eligibility by closure of the file due to a provider's failure to
8011 comply with time frames for submitting a certification request under
8012 Section 240.1600(b);
8013
8014 3) new supporting documentation to establish eligibility for certification or
8015 recertification as a service provider under the CCP following failure to
8016 comply with time frames for submitting material requested by the
8017 Department;
8018
8019 4) issues upon which the Department has already made a final administrative
8020 decision as a result of a previous objection or contract action involving the
8021 provider;
8022
8023 5) issues upon which an independent trier of fact has made a final
8024 determination or issued an order;
8025
8026 6) disputes as to service rates or the underlying methodology for calculating
8027 those rates;
8028
8029 7) duration of a service provider certification;
8030
8031 8) timing of the Provider Agreement process by the Department; or
8032
8033 9) other matters of general applicability that are not specifically adverse to
8034 the provider.
8035
8036 c) Procedures for Filing an Objection
8037
8038 1) An objection regarding a certification decision must be in writing and
8039 must be received at the Department's Springfield office on or before the
8040 tenth~~10th~~ calendar day after the date of the applicant's receipt of the notice
8041 of the objectionable action. If the objection is not received before the
8042 close of business on the ~~10th~~ tenth calendar day, the objection shall be
8043 disregarded.

2) Each objection must contain a full and concise statement of the facts and circumstances of the action that is alleged to be objectionable, legally or otherwise, and a statement of the relief sought.

A) The Department may request additional details at any time.

B) Failure to supply any information requested by the Department will be cause for dismissal of the objection.

d) Upon receipt of written objection, the Department shall immediately review the certification decision in question and shall issue a written response. The certification decision shall not be considered final until any relevant objections are resolved.

e) The decision of the Director is final and shall be sent by ~~certified~~ mail or email.~~, return receipt requested, or by any other means that allows the Department to document and confirm receipt by the applicant of the decision.~~

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1650 Classification, Identification and Receipt of Provider Service Violations

Failure to comply with the contract, proposal and Department rules shall be identified and classified by the Department.

a) In determining the classification assigned to each provider service violation, the Department shall consider the following:

1) the severity of the violation;

2) the danger posed by the violation to the health, safety or welfare of the participant, based upon degree of participant impairment and availability of support sources;

3) the provider's efforts to correct violations;

4) the volume and scope of violations.

b) There are three~~3~~ classifications of violations: Type I, Type II and Type III.

1) Type I provider service violations are participant-centered violations that pose an imminent risk to the health, safety or welfare of the CCP

8087 participant, and represent situations in which failure to correct the
8088 violation could result in the participant's potential hospitalization or
8089 nursing facility placement. Type I violations shall receive priority
8090 attention, requiring immediate (within 24 hours) correction to remove the
8091 risk environment. Permanent correction must be achieved within 60
8092 calendar days.
8093
8094 2) Type II provider service violations are participant-centered violations that
8095 pose a potentially serious risk to the participant. These violations are to be
8096 corrected within 60 calendar days.
8097
8098 3) Type III provider service violations are administrative violations that pose
8099 a very low risk to the participant. The time frame for correction of Type
8100 III violations shall be 60 calendar days or as established in an approved
8101 work plan.
8102
8103 c) Provider service violations include, but are not limited to, violation of the
8104 following CCP rules:
8105
8106 1) adult day service standard requirements (Section 240.1550);
8107
8108 2) adult day service and in-home provider staffing requirements (Sections
8109 240.1530 and 240.1555);
8110
8111 3) special services (Subpart J);
8112
8113 4) provider administrative minimum standards and responsibilities (Sections
8114 240.1510, 240.1520, 240.1542, 240.1544 and 240.2020);
8115
8116 5) service components (Sections 240.210, 240.230, 240.235, 240.237 and
8117 240.270);
8118
8119 6) adult day service and in-home provider staff qualification and
8120 responsibilities (Sections 240.1535 and 240.1560);
8121
8122 7) service provision requirements (Subpart B and Section 240.915);
8123
8124 8) emergency home response equipment (Section 240.1541);
8125
8126 9) AMD equipment (Section 240.1543).
8127
8128 d) The Department will be in receipt of reported violations through the following
8129 methods:

8130
8131 1) Performance reviews of contracted provider agencies (Section 240.1660);
8132
8133 2) Service complaints/violations that are reported directly to the Department
8134 or to the Senior HelpLine of the Department or are referred to the Senior
8135 HelpLine by the Department/CCU or service provider/other; and/or
8136
8137 3) Reports from Department staff.
8138
8139 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
8140
8141 **Section 240.1660 Provider Performance Reviews**
8142
8143 a) Providers under contract to the Department must comply with federal, State and
8144 local laws, regulations, Department rules and the contract requirements. When
8145 the provider signs the contract, this signature shall be the provider's certification
8146 that all applicable laws, rules and regulations, contract requirements, and
8147 statements included in the Provider Proposal shall be complied with. The
8148 Department shall have the authority to conduct performance reviews of a
8149 contracted provider agency at any time during the course of the provider's
8150 contract period. Any findings and/or contract actions resulting from a
8151 performance review may be appealed (see Section 240.1661).
8152
8153 b) The Provider Performance Review consists of a sample of rules, of RFP
8154 requirements, and of cases that will be reviewed for performance.
8155
8156 c) If non-performance findings result from the Provider Performance Review, the
8157 provider shall receive a written report of the findings and have a specified period
8158 of time for adherence. The allowable time period shall be relevant to the
8159 classification of the violation and the applicable corrective action time frames
8160 specified in Section 240.1650.
8161
8162 d) If non-performance findings result from the follow-up review, the Department
8163 may impose one~~1~~ or more of the contract actions specified in Section 240.1665.
8164
8165 e) The Department may initiate the termination of the provider agreement after three
8166 consecutive performance reviews resulting in non-compliance findings as
8167 indicated on the written report.
8168
8169 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
8170
8171 **Section 240.1661 Provider and Care Coordination Unit Right to Appeal**
8172

8173 The provider and CCU have the right to appeal any finding and/or contract action ~~(see Section~~
8174 ~~240.1665)~~ resulting from a performance review. Any contract action, including termination, will
8175 proceed during the appeal process. ~~(see Sections 240.1660 and 240.1720).~~
8176
8177 a) Upon receipt of ~~the Provider or CCU Performance Review report of non-~~
8178 ~~performance findings and the~~ written notification of contract actions to be taken, a
8179 provider or CCU may request an appeal in writing within 15 calendar days
8180 ~~wanting to appeal must do so in such a manner that the appeal is received at the~~
8181 ~~Department's Springfield Office on or before the 15th work day~~ from the date of
8182 the notice. If the request for appeal is not filed within~~received before the close of~~
8183 ~~business on the~~ 15th calendar days~~work day~~, the appeal shall be automatically
8184 denied~~disregarded~~.
8185
8186 b) Appeals shall be submitted in the manner and form specified by the Department
8187 and shall be mailed or emailed~~addressed~~ to the Office of General Counsel (OGC)
8188 in Springfield.~~and delivered or mailed to the Department's main office (see~~
8189 ~~Section 240.150):~~
8190
8191 c) The OGC~~General Counsel~~, with appropriate Department staff, will conduct an
8192 informal review ~~the appeal~~ and make a recommendation to the Director ~~for final~~
8193 ~~decision~~.
8194
8195 d) The OGC may contact the appellant to discuss the appeal request and/or request
8196 additional information.
8197
8198 e) The OGC shall submit a recommendation to the Director within 60 days after
8199 receipt of the appeal or receipt of the requested information, whichever is later.
8200
8201 f) The Director may accept or reject all or part of the recommendation.
8202
8203 1) If the Director determines that the finding and/or contract action is
8204 ~~determined by the Director to be~~ valid, the appeal will be denied and the
8205 finding/action shall be upheld/implemented.
8206
8207 2) If the Director determines that the finding and/or contract action is
8208 ~~determined by the Director to be~~ invalid, the appeal shall be upheld and
8209 the finding/action shall be modified or expunged, in whole or in part, with
8210 letter~~evidence~~ placed in the provider or CCU file.
8211
8212 g~~d~~) The Director may determine that the circumstances causing the contract actions
8213 warrant a hearing that shall be conducted at a location designated by the
8214 Department.
8215

~~1) The provider or CCU may bring appropriate representation and written appeal data to the hearing.~~

~~2) Appropriate Department staff shall be in attendance at the hearing.~~

h~~e~~) All hearings shall be conducted by an impartial Hearing Officer authorized by the Director~~in accordance with Department hearing rules (89 Ill. Adm. Code 220.500 through 220.520)~~.

i) The Hearing Officer may schedule one or more pre-hearing conferences.

j) The Department and the appellant will provide copies of relevant documents, a list of potential witnesses, and a summary of potential testimony to be used at the hearing, to the other party. Depositions, interrogatories, other discovery mechanisms may be used upon the mutual consent of the parties. The hearing officer shall exclude immaterial, irrelevant, or unduly repetitious evidence.

k) The hearing shall be conducted in accordance with Article 10 of the Illinois Administrative Procedure Act [5 ILCS 100] unless otherwise specified in this Part. Unless otherwise provided by law, the burden of proof will be by the preponderance of the evidence and will be on the moving party or the party bringing the action.

l) The hearing may be conducted in person or with some or all parties, including the Hearing Officer, present at different locations connected with each other by telephone, videoconference, or other electronic means. The proceedings will be recorded.

m) The appellant or a Department Representative may request a continuance, which shall be in writing to the Hearing Officer before the scheduled hearing date. A verbal request may be made when the hearing is convened. The Hearing Officer may continue the hearing to another date acceptable to all parties and the Hearing Officer.

n) The appellant may withdraw the appeal at any time prior to or during the appeal process. The withdrawal must be submitted in writing and the Department will close the appeal file. If the withdrawal occurs after the appeal has been assigned to a Hearing Officer, the withdrawal must be submitted in writing to the Hearing Officer and the Department. The Hearing officer will make an oral finding on the record that the appeal has been withdrawn.

o) The failure to appear by the appellant or to proceed with the hearing is considered a non-appearance. The appeal is considered abandoned and shall be dismissed.

Dismissal of an appeal is a final administrative decision.

p) Within ten calendar days after the date of the dismissal notice, the appellant may request the reinstatement of the appeal sent in writing to the Hearing Officer and Department. The appellant's request must contain facts and supporting documentation, where applicable, to support the reinstatement. The Hearing Officer may or may not reinstate the appeal.

q) The Hearing Officer shall certify the entire record of the hearing to the Director and shall recommend a decision on each issue in the hearing within 60 calendar days from the close of evidence and argument in the appeal. The Hearing Officer shall not render a final decision relevant to any issue in the hearing.

r) The Director may accept or reject all or part of the recommendations. Their decision shall be made by applying the Department's rules to the particular case situation.

s) The Director shall issue their decision in writing no later than 90 calendar days after the Hearing Officer's recommendation. The Department shall send a copy of the decision to the parties of the appeal by mail or email. The Director's decision is final.

t) At any time within five years after the date of the release of the Department's final administrative decision, upon written request to the Office of General Counsel, the appellant/authorized representative may review the official report of the hearing.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1665 Contract Actions for Failure to Comply with Community Care Program Requirements

The Department may impose one~~1~~ or more of the following contract actions upon any CCP provider or contracted CCU that fails to comply with Department rules or contract/Provider Agreement requirements, including any statements made on the CCU Proposal or the provider's application for certification. These actions include:

a) prohibition of specified staff from serving CCP participants (imposed when the Department finds that a worker, case manager, supervisor or other designated staff fails to comply;

b) purchase of a limited financial audit (imposed when the Department finds that a provider or CCU has failed to adhere to the fiscal requirements specified in this

8302 Part);
8303
8304 c) suspension of referrals for up to 90 days;
8305
8306 d) transfer of a portion of the participants served under the contract or Provider
8307 Agreement;
8308
8309 e) training of staff;
8310
8311 f) termination of Provider Agreement or CCU contract and transfer of all
8312 participants;
8313
8314 g) requiring a review by the provider or CCU of all or a specified subset of files and
8315 provider or CCU certification of corrective action;
8316
8317 h) requiring the provider or CCU to contract with an outside management firm to
8318 evaluate program management and to implement recommendations for
8319 improvement as provided in the evaluation and negotiated with the Department;
8320
8321 i) suspending all or a portion of CCP payments until the action is corrected;
8322
8323 j) deducting overpayments to provider or CCU from future Provider or CCU
8324 Requests for Payment or requiring the provider or CCU to reimburse the
8325 Department;
8326
8327 k) refusing to accept a proposal from a CCU or to enter into a Provider Agreement
8328 with the provider in one1 or more specified areas open for procurement; and/or
8329
8330 l) taking any other action the Director determines to be appropriate to the non-
8331 performance circumstances.
8332
8333 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
8334
8335 **Section 240.1666 Termination of Provider Agreement**
8336
8337 a) If the Department terminates a provider agreement, the provider cannot reapply
8338 for certification until six months after the receipt of the termination letter or the
8339 conclusion of an appeal process, whichever is later. This prohibition on
8340 reapplying extends to the owners and/or administrators of the provider agency.
8341
8342 b) If the Department terminates a provider a second time, then the provider is
8343 prohibited from applying for another agreement for a year after the receipt of the
8344 termination letter or the conclusion of an appeal process, whichever is later. This

prohibition on reapplying extends to the owners and/or administrators of the provider agency.

c) To reapply for certification after a termination, the provider must provide a corrective action plan that addresses each of the corrective actions listed in the termination letter and last QI review report. The plan must list concrete steps that the provider will take to ensure these issues will not continue under a new agreement.

d) The Department will deny a new application if the provider fails to provide an adequate corrective action plan.

(Source: Added at 48 Ill. Reg. ______, effective ____________)

SUBPART R: ADVISORY COMMITTEE

Section 240.1800 Community Care Program Advisory Committee

a) The Director shall appoint individuals to serve on the Community Care Program Advisory Committee (CCPAC) that shall advise the Department on rates of reimbursement for the CCP service delivery network and issues affecting the CCP service delivery network and recommend solution strategies. The CCPAC shall meet on a bi-monthly basis.

b) Persons appointed to the CCPAC shall be appointed based upon their experience with the CCP, geographic representation, and willingness to serve. Representatives shall serve at their own expense and must abide by all applicable ethics laws. Representatives will be appointed to represent older adults and provider, advocacy, policy research and other constituencies committed to the delivery of high quality in-home and community-based services to older adults. Representatives shall be appointed to assure representation from:

1) adult day service providers;

2) in-home service providers;

3) CCUs;

4) emergency home response providers;

5) statewide trade or labor unions that represent homecare aides and direct care staff;

8388 6) Area Agencies on Aging;
8389
8390 7) adults over age 60;
8391
8392 8) membership organizations representing older adults; and
8393
8394 9) other organizational entities, providers of care, and/or individuals
8395 determined by the Director to have demonstrated interest and expertise in
8396 the fields of in-home and community-based care.
8397
8398 c) Nominations may be presented from any agency or State association with interest
8399 in the CCP.
8400
8401 d) The Director, or designee, will serve as permanent Co-chair of the CCPAC . One
8402 other Co-chair shall be nominated and approved annually by members of the
8403 CCPAC.
8404
8405 e) The Director will designate Department staff to provide technical assistance and
8406 staff support to the Committee. Department representation will not constitute
8407 membership on the CCPAC.
8408
8409 f) Terms of appointment will be for four~~4~~ years. Members shall continue to serve
8410 until their replacements are named.
8411
8412 g) The Department will fill vacancies that have a remaining term of over one~~1~~ year,
8413 and this replacement will occur through the annual replacement of expiring terms.
8414
8415 h) All papers, issues, recommendations, reports and meeting memoranda will be
8416 advisory only. The Director, or designee, will make a written response/report, as
8417 requested, regarding issues before the CCPAC.
8418
8419 i) The Director retains full decision making authority on the CCP regarding any
8420 recommendations presented by the CCPAC.
8421
8422 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
8423
8424 SUBPART S: PROVIDER RATES
8425
8426 **Section 240.1910 Establishment of Fixed Unit Rates**
8427
8428 Rate methodologies and rates of payment for the Persons who are Elderly ~~Elderly Medicaid~~
8429 ~~HCBS~~ Waiver program are developed by the Department with consultation, oversight, and final
8430 approval by HFS, the State Medicaid agency. During the Waiver's five~~5~~-year renewal process,

the federal Centers for Medicare and Medicaid Services review the State's Elderly Waiver compliance, including rate sufficiency.

a) The fixed unit rates will be reviewed annually, at a minimum, and adjustments will be made to conform to CCP's appropriation and to program service requirements and federal and State changes in statutes and rules affecting CCP.

b) In establishing fixed unit rates of reimbursement, the Department will take into consideration the following:

1) cost information provided by service providers;

2) current market conditions and trend analyses; and

3) CCP appropriation levels.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1930 Fixed Unit Rate of Reimbursement for In-home Service

The Department will establish a fixed unit rate of reimbursement for in-home service exclusive of those services defined in Section 240.270. Current providers will be notified in writing of any change in the fixed unit rate. The fixed unit rate of reimbursement will be published on the Department's website~~in the official State newspaper~~.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1940 Fixed Unit Rates of Reimbursement for Adult Day Service and Transportation

The Department will establish fixed unit rates of reimbursement for adult day service and transportation as defined in Section 240.230. Current providers will be notified in writing of any change in the fixed unit rate. The fixed unit rates of reimbursement will be published on the Department's website~~in the official State newspaper~~.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1950 Adult Day Service Fixed Unit Reimbursement Rates

Adult day service providers ~~under contract with the Department~~ shall be uniformly reimbursed for the provision of adult day service at the rates established by the Department. The reimbursable units of adult day services shall be as follows:

a) One unit of adult day service is defined in Section 240.230(c)(1) as one~~1~~ direct participant contact hour (excluding transportation time) provided to a participant.

b) One unit of documented adult day transportation provided by the adult day service provider is defined in Section 240.230(c)(2) as a one-way~~1-way~~ trip per participant to or from the adult day site and the client's home.

1) No more than two~~2~~ units of transportation shall be provided per participant in a 24 hour period.

2) A unit of transportation shall not include transportation on outings, trips to physicians, shopping or other miscellaneous trips.

(Source: Amended at 48 Ill. Reg. ______, effective ____________)

Section 240.1955 Fixed Unit Rates of Reimbursement for Emergency Home Response Service

EHRS providers ~~executing a contractual agreement with the Department pursuant to Section 240.1600~~ shall be uniformly reimbursed for the provision of EHRS at fixed unit rates of reimbursement established by the Department. The reimbursable units of EHRS shall be as follows:

a) Installation and Removal
The Department shall pay a one~~1~~-time installation fee at a fixed unit reimbursement rate established by the Department for the installation of the base unit in the participant's home. The Department shall not pay any fee for expenses incurred by the EHRS provider if service could not be provided due to either the participant's absence or the participant's refusal to admit the EHRS provider's employee into the home. The Department shall not pay any fee for removal of the base unit.

b) Monthly Service
The Department shall pay a monthly service fee per participant at a fixed unit reimbursement rate established by the Department for providing EHRS to participants. The Department shall not pay for the cost of maintaining telephone service for the participants or any associated charges or fees.

c) The rates will be reviewed annually, at a minimum. Adjustments may be made to conform to the appropriation, service requirements and/or changes in federal and State laws, regulations and/or rules affecting the service.

d) In establishing the rates of reimbursement, the Department will comply with

8517 federal requirements for Medicaid waivers, which are described in the State
8518 Medicaid Plan maintained by HFS and posted on the HFS website. The
8519 Department will use a Request for Information process to obtain rate information
8520 from providers and then consider whether the resulting average is supported by
8521 the appropriation level for the program in light of trend analyses on use of the
8522 service and current market conditions. The goal is to ensure adequate provider
8523 participation and participant choice. The specific amount that the service provider
8524 will be reimbursed for a unit of service is reflected in the provider contract and is
8525 listed on the Department's website.
8526
8527 e) Upon written notification from the Department of a change in the rates of
8528 reimbursement, an EHRS~~AMD~~ provider may exercise its 60 calendar day
8529 termination rights if the EHRS provider no longer wishes to provide services
8530 thereafter at the new rates of reimbursement.
8531
8532 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
8533
8534 **Section 240.1957 Fixed Unit Rates of Reimbursement for Automated Medication**
8535 **Dispenser Service**
8536
8537 AMD service providers ~~executing a contractual agreement with the Department pursuant to~~
8538 ~~Section 240.1600~~ shall be uniformly reimbursed for the provision of AMD units at fixed unit
8539 rates of reimbursement established by the Department. The reimbursable units of AMD service
8540 shall be as follows:
8541
8542 a) Installation, Initial Training and Removal
8543 The Department shall pay a one~~1~~-time installation fee at a fixed unit
8544 reimbursement rate established by the Department for the installation and initial
8545 training of the participant/authorized representative/responsible party of the AMD
8546 unit in the participant's residence. The Department shall not pay any fee for
8547 expenses incurred by the AMD provider if service could not be provided due to
8548 either the participant's absence or the participant's refusal to admit the AMD
8549 provider's employee into the residence. The Department shall not pay any fee for
8550 removal of the AMD unit.
8551
8552 b) Monthly Service
8553 The Department shall pay a monthly service fee per participant at a fixed unit
8554 reimbursement rate established by the Department for providing AMD service
8555 that includes maintaining administrative and technical support to program
8556 machines; providing 24 hour technical assistance and additional training; signal
8557 monitoring, troubleshooting, machine maintenance, repair and replacement;
8558 notifications to the responsible party on missed medication doses and power
8559 outage; tracking and analyzing data; and providing reports as requested by the

8560 Department. The Department will not pay for the cost of maintaining telephone
8561 service for the participant or any associated charges or fees.
8562
8563 c) The rates will be reviewed annually, at a minimum, and adjustments may be made
8564 to conform to the appropriation, service requirements and/or changes in federal
8565 and State laws, regulations and/or rules affecting the service.
8566
8567 d) In establishing the rates of reimbursement, the Department may consider any of
8568 the following factors:
8569
8570 1) appropriation levels;
8571
8572 2) cost information provided by the providers; and/or
8573
8574 3) current market conditions and trend analyses.
8575
8576 e) Upon written notification from the Department of a change in the rates of
8577 reimbursement, an AMD provider may exercise its 60 calendar day termination
8578 rights if the AMD provider no longer wishes to provide services thereafter at the
8579 new rates of reimbursement.
8580
8581 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
8582
8583 **Section 240.1960 Care Coordination Fixed Unit Reimbursement Rates**
8584
8585 Care Coordination Units under contract with the Department shall be uniformly reimbursed for
8586 the provision of CCP care coordination services at the rates established by the Department. The
8587 reimbursable CCP care coordination service activities subsequent to a procurement ~~conducted~~
8588 ~~under 89 Ill. Adm. Code 220.610 through 220.675~~ as follows:
8589
8590 a) completion of each initial eligibility determination for CCP services;
8591
8592 b) completion of each redetermination of CCP eligibility not to exceed one~~1~~
8593 redetermination per month per participant;
8594
8595 c) completion of each face-to-face screening of a participant;
8596
8597 d) completion of each HFS Interagency Certification of Results – Determination of
8598 Imminent Risk form, following prescreening by Choices for Care screeners;
8599
8600 e) completion of each HFS ~~OBRA-1 (~~Level I~~-ID~~ Screen~~)~~;
8601
8602 f) availability to receive participant inquiries and requests, by telephone or in

8603 person, and to respond to those requests and inquiries for each active participant
8604 per month;
8605
8606 g) completion of each Deinstitutionalization assessment;
8607
8608 h) completion of one face-to-face visit between initial assessment and annual
8609 reassessment that is to occur between four~~4~~ and eight~~8~~ months after the last
8610 determination or redetermination of eligibility.
8611
8612 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
8613
8614 **Section 240.1970 Enhanced Rate for Health Insurance Costs**
8615
8616 The Department may be appropriated funds to pay an enhanced rate under CCP to those in-home
8617 service provider agencies that offer health insurance coverage as a benefit to their direct service
8618 worker employees.
8619
8620 a) Definitions
8621 For purposes of this Section:
8622
8623 "Direct service worker" means an employee who provides homecare aide services
8624 for an in-home service provider agency under CCP.
8625
8626 "Health insurance" means a Type 1 plan or a Type 2 plan.
8627
8628 1) Type 1 Plan
8629 A Type 1 plan must comply with, be comparable to, or exceed required
8630 mandated benefits, coverages, and co-payment levels for individual and
8631 group insurance policies under the Illinois Insurance Code [215 ILCS 5]
8632 and 50 Ill. Adm. Code, Subchapter ww and individual and group contracts
8633 for health maintenance organizations under the Health Maintenance
8634 Organization Act [215 ILCS 125] and 50 Ill. Adm. Code 4521.
8635
8636 2) Type 2 Plan
8637 A Type 2 plan is employer-paid health insurance as part of collective
8638 bargaining with unionized direct service workers through a Taft-Hartley
8639 Multi-employer Health and Welfare Plan that defines the eligibility
8640 requirements and coverage under section 302(c)(5) of the Labor
8641 Management Relations Act of 1947 (29 U.S.C.~~USC~~ 141).
8642
8643 b) Initial Application

8644 An interested in-home service provider agency must submit an initial application
8645 at least 120 days prior to the end of each State fiscal year. Applications will be
8646 accepted by the Department at its main office located in Springfield.
8647
8648 c) Eligibility
8649 Eligibility requirements include:
8650
8651 1) Verification of a current contract as an in-home service provider agency
8652 with the Department under CCP.
8653
8654 2) A copy of a health insurance plan or a certificate of insurance, and the
8655 effective date of that document, to establish that:
8656
8657 A) the in-home service provider agency provides health insurance at
8658 its own expense to its direct service workers, which may include
8659 coverage for those employees' dependents; or
8660
8661 B) the in-home service provider agency will provide for health
8662 insurance as part of collective bargaining with unionized direct
8663 service workers, which may include coverage for those employees'
8664 dependents through a Taft-Hartley Multi-employer Health and
8665 Welfare Plan.
8666
8667 3) Specification of the total number of employees and the total number of
8668 direct service workers, together with a certification from a responsible
8669 party for the in-home service provider agency to the effect that:
8670
8671 A) under a Type 1 health insurance plan:
8672
8673 i) health insurance coverage is offered to all direct service
8674 workers who have worked at least an average of 20 hours
8675 per week for three~~3~~ consecutive months under the CCP;
8676 and
8677
8678 ii) at least 25% of the total number of direct service workers
8679 accept the offer of health insurance.
8680
8681 B) under a Type 2 health insurance plan:
8682
8683 i) health insurance coverage is offered to all of the direct
8684 service workers subject to the collective bargaining
8685 agreement who have worked at least an average of 20 hours

per week for three~~3~~ consecutive months under the CCP; and

ii) at least 25% of the total number of direct service workers, or any higher percentage required under federal law, accept the offer of health insurance.

4) Submission of any other relevant information requested by the Department for administrative or audit purposes.

d) Impact on Financial Reporting

1) An in-home service provider agency shall not report the enhanced rate for health insurance costs paid by the Department under this Section as part of its revenue for purposes of the required financial reporting under Subpart T.

2) An in-home service provider agency shall not report health insurance for direct service workers as an incurred cost for purposes of the required financial reporting under Subpart T, except for an amount in excess of the enhanced rate paid by the Department during a reporting period.

e) Payment

1) If an in-home service provider agency is determined eligible for this enhanced rate, the Department will thereafter calculate the appropriate payment based on the number of units of in-home service accepted as billed per contract once the provider agency submits its VRFP under the CCP (see Section 240.1520) for reimbursement under this Section. Payments may be adjusted by the Department to properly account for services provided to participants. Payment is subject to the availability of appropriations during the State fiscal year.

2) An in-home service provider agency that makes a switch between a Type 1 and a Type 2 plan is not entitled to any retroactive payments for a period of time preceding the date on which benefits are actually available under the new plan.

3) No in-home service provider agency is entitled to a duplicate payment for the same period of time or for the same units of in-home service accepted as billed per contract.

8728 4) By accepting any payment under the CCP, an in-home service provider
8729 agency agrees to repay the State of Illinois if:
8730
8731 A) the total revenue from the enhanced rate for health insurance costs
8732 exceeds the actual, documented expenses for its healthheath
8733 insurance costs for the reporting period; or
8734
8735 B) an error in eligibility of an in-home service provider agency or the
8736 amount of revenue from the enhanced rate for health insurance or
8737 the amount of the health insurance costs is subsequently
8738 determined by an in-home service provider agency or the
8739 Department.
8740
8741 5) In the case of a financial or operational hardship, the Department may
8742 deduct an overpayment from future VRFPs submitted by the in-home
8743 service provider agency instead of collecting a lump-sum amount.
8744
8745 f) Notification
8746 It is the responsibility of an in-home service provider agency to notify the
8747 Department within seven7 days after any change in its eligibility status, including,
8748 but not limited to, cancellation or termination of the health insurance plan or
8749 purchase of a new plan. An in-home service provider agency is only required to
8750 monitor participation by direct service workers in order to submit the initial
8751 application, the annual insurance review, and required financial reporting.
8752
8753 g) Annual Insurance Review
8754
8755 1) Once an in-home service provider agency is determined eligible by the
8756 Department and is paid an enhanced rate for health insurance costs, the
8757 provider agency shall thereafter substantiate its continued eligibility under
8758 subsection (c) by submitting appropriate supporting documentation at the
8759 same time as its annual financial report under Subpart T.
8760
8761 2) As part of the annual insurance review, an independent certified public
8762 accounting firm for the in-home service provider agency must verify the
8763 actual, documented expense for health insurance for the period listed as
8764 part of the required financial reporting under Subpart T.
8765
8766 3) The Department reserves the right to require an in-home service provider
8767 agency to engage an independent certified public accounting firm to verify
8768 the information and data submitted by the provider agency if the
8769 Department is in possession of evidence to suggest the information and

8770 data submitted is inaccurate, incomplete or fraudulent. This audit will be
8771 performed at the in-home service provider agency's expense.
8772
8773 4) The Department shall notify an in-home service provider agency in the
8774 event of a determination during the annual insurance review that:
8775
8776 A) the in-home service provider agency is no longer eligible for
8777 continued payment of the enhanced rate for health insurance costs;
8778
8779 B) the total revenue from the enhanced rate for health insurance costs
8780 exceeds the actual, documented expenses for health insurance costs
8781 for the reporting period;
8782
8783 C) there was an error in eligibility of an in-home service provider
8784 agency for the prior reporting period;
8785
8786 D) there was an error in the amount of revenue from the enhanced rate
8787 for health insurance costs; or
8788
8789 E) there was an error in the amount of the health insurance costs.
8790
8791 5) An in-home service provider agency may appeal from an adverse
8792 eligibility decision regarding continued payment of the enhanced rate for
8793 health insurance costs or a repayment decision in accordance with Section
8794 240.1661. The Department will continue to pay the enhanced rate for
8795 health insurance costs until the appeal is resolved.
8796
8797 6) Supporting documentation may be subject to release under the Freedom of
8798 Information Act unless an applicable exemption for confidentiality,
8799 privacy, or other proprietary business purpose is marked on the face of any
8800 submission.
8801
8802 (Source: Amended at 48 Ill. Reg. ______, effective ____________)
8803
8804 SUBPART T: FINANCIAL REPORTING
8805
8806 **Section 240.2020 Financial Reporting of In-home Service**
8807
8808 a) Provider agencies will be required to submit a cost report as described in this
8809 Section (Direct Service Worker Cost Certification). The report must be based
8810 upon actual, documented expenditures.
8811
8812 1) The report must be submitted annually, within six~~6~~ months after the end of

8813 the reporting period, and may be prepared as a part of the provider's
8814 annual audit.
8815
8816 2) The report may be on either a calendar year basis or the provider's fiscal
8817 year (once a provider has elected to base the reports on a calendar or fiscal
8818 year, this election can be changed only upon written approval of the
8819 Department).
8820
8821 b) The cost report must demonstrate that the provider has expended a minimum of
8822 77% of the total revenues due from the Department, to include the participant
8823 incurred expense that may have been applicable prior to July 1, 2010, for direct
8824 service worker costs as enumerated in Section 240.2050. For purposes of this
8825 report, the phrase "total revenues due from the Department" does not include any
8826 amount received as an enhanced rate for health insurance costs by a qualifying in-
8827 home service provider.
8828
8829 c) The cost report shall identify the provider's expenditures for direct service worker
8830 costs of program support costs and administrative costs as enumerated in Section
8831 240.2050.
8832
8833 d) The accuracy of the report must be attested to by an authorized representative of
8834 the provider.
8835
8836 e) The Department reserves the right to require the provider to engage an
8837 independent certified public accounting firm to verify the information and data
8838 submitted by the provider if the Department is in possession of evidence to
8839 suggest the information and data submitted is inaccurate, incomplete or
8840 fraudulent. This audit will be performed at the provider's expense.
8841
8842 (Source: Amended at 48 Ill. Reg. ______, effective ____________)