**Section 120.70 Service provider requirements**

a) New and current provider agencies must be enrolled as a Medicaid provider in the Illinois Medical Program Advanced Cloud Technology (IMPACT) system with HFS.

b) The provider shall meet Department standards applicable to the specific services to be provided and shall demonstrate competency to provide services.

c) Service providers shall:

1) Meet the fiscal, program, and reporting requirements of the Medicaid HCBS Waiver programs

2) Be willing to serve eligible individuals from a variety of backgrounds including, but not limited to, former or potential residents of State-operated facilities or ICF/DDs;

3) Comply with applicable Medicaid provider requirements, appropriate licensure procedures, and/or standards, as well as Department operational procedures for purchase of service or grant programs (see the Department's Rules at 59 Ill. Adm. Code 103, 113, 115 and 119); and

4) Comply with intake, assessment, monitoring, and billing procedures established for services under this Part.

d) Provider-owned or -controlled residential and non-residential settings must have all of the following qualities, and other qualities as determined to be appropriate, based on the needs of the Individual as indicated in their Personal Plan (42 CFR 441.301(c)(4)):

1) Be integrated in and support full access of Individuals receiving Medicaid HCBS to the greater community, including opportunities to:

A) Seek employment and work in competitive integrated settings;

B) Engage in community life, to the extent chosen by the Individual;

C) Control personal resources; and

D) Receive services in the community, to the same degree of access as Individuals not receiving Medicaid HCBS.

2) Be selected, with the assistance of the ISC agency, by the Individual from among setting options including non-disability specific settings and an option for a private bedroom or unit in a residential setting. The setting options are identified and documented by the ISC agency in the Personal Plan and are based on the Individual's needs, preferences, and, for residential settings, resources available for room and board. When feasible, the provider agency should offer the option for a private bedroom or unit in a residential setting.

3) Ensure an Individual's rights to privacy, dignity and respect, and freedom from coercion and restraint.

4) Optimize, but not regiment, Individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.

5) Facilitate Individual choice regarding services and supports and who provides them.

6) Provider-owned or -controlled residential settings, in addition to the qualities described in subsections (d)(1) through (d)(5), must meet the following additional conditions:

A) The residential setting is a specific physical place that can be owned, rented, or occupied under a legally-enforceable agreement (consistent with the guidelines issued by the Department) by the Individual receiving services, and the Individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, and/or other designated entity. For settings in which landlord/tenant laws do not apply, the State must ensure that a lease, residency agreement, or other form of written agreement, as determined by the Department, will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.

B) Each Individual has privacy in their residential setting.

i) Residential settings shall have entrance doors lockable by the Individual, with only appropriate staff having keys to doors.

ii) Individuals sharing a residential setting shall have a choice of roommates in that setting.

iii) Individuals shall have the freedom to furnish and decorate their residential setting within the lease or other agreement.

C) Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

D) Individuals can have visitors of their choosing at any time.

E) The setting is physically accessible if required by the needs of any Individuals served in the setting. Providers should access all available resources, through the Division and community, to accommodate accessibility needs. All communal areas must meet standards set forth by the ADA and other federal, State, or municipal regulations. Providers must ensure sites are certified and have capacity for a non-ambulatory Individual before offering placement. The non-ambulatory capacity is indicated in the certification letter given to each provider by the Department for every site.

F) Any modification of the additional conditions, under subsections (d)(6)(A) through (E), must be supported by a specific assessed need and justified in the Personal Plan. The following requirements must be documented in the Personal Plan and Implementation Strategy:

i) Identify a specific and individualized assessed need.

ii) Document the positive interventions and supports used prior to any modifications to the Personal Plan.

iii) Document less intrusive methods of meeting the need that have been tried but did not work.

iv) Include a clear description of the condition that is directly proportionate to the specific assessed need.

v) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

vii) Include the informed consent of the Individual and guardian.

viii) Include an assurance that interventions and supports will cause no harm to the Individual.

e) Providers who deliver authorized services to Individuals determined eligible under the Medicaid HCBS Waiver Programs shall be paid by the Department on a monthly basis on submission of service reports/billing statements.

f) Providers shall cooperate with:

1) Quality assurance reviews, monitoring, evaluations, information requests (conducted by the Department, HFS, or by other entities that are authorized by the Department or HFS, such as ISC agencies, auditors, or evaluators) and when necessary, sanctions. Prior to initiating formal action to sanction a provider agency, the Department will allow the provider an opportunity to take corrective action to eliminate or ameliorate a deficiency except in cases in which the Department determines that emergency action is necessary to protect the public or individual interest, safety, or welfare.

2) Licensure and certification surveys, monitoring, evaluations and information requests, (conducted by the Department) and when necessary, sanctions. The Department will conduct onsite surveys of providers to ensure that they maintain compliance with established rules, regulations, and standards. Providers who fail to comply with the established rules, regulations, and standards set forth by the Department shall receive sanctions that include hold on admissions or payment, decertification of a site, and licensure revocation. Once a provider comes into compliance, the sanction shall be lifted, and the Department will proceed with the required survey process unless the Department has decertified a site or revoked the license in which case the sanction will not be lifted.

g) Provider agencies shall only use Restraint as allowed and directed pursuant to statutes and administrative rules applicable to the program (i.e., 59 Ill. Adm. Code 115, 59 Ill. Adm. Code 119, 77 Ill. Adm. Code 370, 89 Ill. Adm. Code 384, 89 Ill. Adm. Code 401, 89 Ill. Adm. Code 403, 210 ILCS 35/18, and 405 ILCS 5). If any type of Restraint not allowed and/or directed by administrative rule applicable to the program is utilized by an Agency employee, the incident must be reported via the Critical Incident Reporting and Analysis System (CIRAS) as well as reported to the Office of the Inspector General.

h) When a provider determines it will reduce, suspend, or terminate services to an Individual in an HCBS Waiver Program, the agency must do so according to the following, unless specified otherwise in the statutes or administrative rules applicable to the program (i.e., 59 Ill. Adm. Code 115, 59 Ill. Adm. Code 119, 77 Ill. Adm. Code 370, 89 Ill. Adm. Code 384, 89 Ill. Adm. Code 401, 89 Ill. Adm. Code 403, 210 ILCS 35/18, and 405 ILCS 5):

1) A provider agency shall terminate its services if an Individual or guardian chooses either of the following actions, both of which are considered voluntary, and the termination is not appealable:

A) An Individual transfers to another qualified provider; or

B) An Individual or Individual's guardian withdraws the Individual from the provider agency's services (with no intention of returning).

2) A provider agency may involuntarily reduce, suspend, or terminate services to an Individual for the following reasons:

A) The medical needs of the Individual cannot be met by the provider agency as documented in the Individual's record.

B) The behavioral needs of an Individual cannot be met by the provider agency to ensure the physical safety of the Individual and/or others as documented in the Individual's record.

3) A notice of reduction, suspension, or termination issued by a provider agency, must:

A) Be in writing.

B) Be sent to the Individual, guardian, and ISC agency.

C) Include a time frame for the action. For involuntary terminations, the provider shall issue the Individual and guardian at least a 30-day notice, except in emergency situations as described in Section 120.110(i).

D) Provide a clear statement of the action to be taken.

E) Provide a clear statement of the reason for the action.

F) Include a complete statement of the Individual's right to appeal, including the provider's grievance process; it must also include the Department's informal review process and HFS' hearing process as described in Section 120.110.

i) Appeals by providers. Provider agencies may appeal the Department's administrative decisions (i.e., licensure or certification denial, notice of deficiencies), and request an administrative hearing as outlined in 89 Ill. Adm. Code 508. Providers may not appeal the Department's decisions related to discharge, termination, or reduction of services to an Individual.

1) As the single State Medicaid agency, HFS is responsible for conducting all provider administrative hearings and rendering the final administrative decision. The appeal requirements and process are contained in HFS's rules at 89 Ill. Adm. Code 104.200 through 104.210.

2) The Department shall conduct informal reviews of provider appeals to attempt to resolve issues without a formal administrative hearing.

(Source: Amended at 48 Ill. Reg. 5279, effective March 21, 2024)