**Section 240.1520 Provider Responsibilities**

a) CCP services shall be purchased only from providers certified by the Department to provide those services.

b) Providers shall carry occurrence based general liability insurance in the single limit minimum amount of $1,000,000 per occurrence, $3,000,000 in the aggregate.

c) Providers shall also carry the following insurance coverages:

1) worker's compensation for direct service staff;

2) volunteer protection equivalent to employees' coverage, including coverage for volunteer drivers/escorts, if applicable; and

3) motor vehicle liability, uninsured motorist and medical payments, if agency staff transport participants in agency vehicles, or proof of minimum motor vehicle liability, uninsured motorist and medical payments, if agency staff transport participants in the staffs' own vehicles.

d) The policies or current letters documenting all provider agency insurance coverage and policies or current letters documenting staff coverage specified in subsection (b) or (c) shall be available to the Department upon request.

e) All providers of CCP services must comply with all applicable local, State and federal statutes, rules and regulations.

f) A provider shall provide services to all CCP participants referred by the CCU, 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 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 licensed 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 Department, within six 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.

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

iv) billing and payment information, plus the underlying documentation to support the units of service submitted to the Department for reimbursement.

2) These records shall be available at all times to the Department, HFS, HHS, and/or any designees, and shall be maintained for at least six years after the termination date of the Provider Agreement. Any records being maintained under this subsection (m) by a provider who ceases to provide the agreed services shall be transmitted in accordance with Subpart K.

n) Providers must notify the Department within seven days after any change in agency information (e.g., acquisition, assignment, consolidation, merger, sale of assets or stock, transfer, etc.) or contact information (e.g., address, telephone, fax, email address, contact person, authorized representative, etc.).

1) Providers must notify the Department at least 30 days in advance of any relocation of their administrative office.

2) Providers must submit documentation of changes in provider name, corporate structure and/or Federal Employer Identification Number to the Office of General Counsel. This documentation shall be reviewed to determine if an assignment of the Provider Agreement has occurred (see Section 240.1607(k)).

o) Providers must conduct a criminal background check, as required by the Illinois Healthcare Worker Background Check Act; an online check of the Adult Protective Services Registry, as required by the Adult Protective Services Act [320 ILCS 20/7.5(c)]; and a check of the HHS exclusion database and the HFS Office of Inspector General database on all agency staff and all regularly scheduled volunteers having access to financial information or one-on-one contact with CCP participants.

1) Provider agencies shall comply with the requirements of the Health Care Worker Background Check Act and the Adult Protective Services Act.

2) Staff refusing to submit to a background check shall not have contact with CCP participants in any capacity.

(Source: Amended at 48 Ill. Reg. 11053, effective July 16, 2024)