

ILLINOIS REGISTER

DEPARTMENT OF HUMAN SERVICES

NOTICE OF PROPOSED RULE

TITLE 59: MENTAL HEALTH  
CHAPTER I: DEPARTMENT OF HUMAN SERVICES

PART: 140  
COMMUNITY-BASED SUPERVISED TRANSITIONAL  
RESIDENTIAL LEVELS OF CARE FOR PERSONS WITH  
MENTAL ILLNESSES

SUBPART A: GENERAL PROVISIONS

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**Comment [MSP1]:** ACCEPTABLE.  
Submit during PUBLIC COMMENT period.

**Comment [MSP2]:** Rate Setting section  
should stay. All references to Capacity Grant is  
not indicated.

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SUBPART C: REQUIREMENTS FOR THE PROVISION OF RESIDENTIAL  
LEVELS OF CARE

Section	
140.200	Consumer Rights and Choices
140.205	General Provisions
140.210	Level of Residential Care
140.215	Supervised Transitional Residential Level of Care

AUTHORITY: Implementing and authorized by the Mental Health Community Services Act [405 ILCS 30] and Section 15.3 of the Mental Health and Developmental Disabilities Administrative Act [20 ILCS 1705/15.3].

Source: Adopted at 36 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

SUBPART A: GENERAL PROVISIONS

**Section 140.10 Purpose**

- a) The purpose of this Part is to assure that consumers receiving Department of Human Services Division of Mental Health funded residential levels of care live in safe, appropriate and therapeutic environments that support recovery and encourage movement to the most integrated setting appropriate that maximize individuals' independence, choice, opportunities to develop and use independent living skills, and afford the opportunity to live equivalent lives to individuals without disabilities.
- b) The Department shall use the requirements set forth in this Part to certify and monitor providers' compliance.
- c) Any entity determined by the Department of Healthcare and Family Services to be an institute for the mentally diseased (IMD) will not be funded by DMH as Supervised Transitional Level of Care.

**Section 140.15 Incorporation by Reference**

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Any rules of an agency of the United States or of a nationally-recognized organization or association that are incorporated by reference in this Part are incorporated as of the date specified, and do not include any later amendments or editions.

**Section 140.20 Coordination of Care**

Providers of community-based residential levels of care, as described in this Part, shall coordinate residential levels of care with services described in 59 Ill. Adm. Code 132 ~~that support the to facilitate~~ consumer's ~~moves toward~~ recovery.

**Comment [MSP3]:** ACCEPTABLE.  
Submit during PUBLIC COMMENT period.

**Section 140.25 Definitions**

For the purpose of this Part, the following terms are defined:

Accessibility - Compliance with all appropriate provisions of the Americans With Disabilities Act (ADA) (42 USC 12101), as amended, and section 504 of the Rehabilitation Act of 1973 (29 USC 794). No otherwise qualified disabled individual shall, solely by reason of a disability, ~~shall~~ be excluded from participation in, be denied the benefits of or be subjected to discrimination in programs, services or activities sponsored by the provider. The provider shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless it can demonstrate that making the modifications would fundamentally alter the nature of the services, program or activity. The provider shall communicate this policy to all visitors, recipients of services, potential recipients of services, and employees. This includes the extent to which a provider has adapted sites where services are provided to render its physical building elements, parking lot, entry, egress, restrooms, circulation paths, telecommunications and technology accessible to persons with disabilities in accordance with the ADA, section 504, Illinois Technology Access Act (IITAA) [30 ILCS 587/], and the most recent standards identified in the Illinois Accessibility Code (71 Ill. Adm. Code 400) and/or ADA Accessibility Guidelines (ADAAG), whichever standard is more stringent, as well as the provider's reasonable modification for the delivery of services to otherwise eligible clients for whom a site is inaccessible.

Abuse - See definitions for physical abuse, sexual abuse, mental abuse and financial exploitation in 59 Ill. Adm. Code 50.

Adult - An individual who is 18 years of age or older.

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Auxiliary Aids and Services - Includes a wide array of devices and services to facilitate effective communication to individuals with disabilities related to sensory, manual, or speaking skills. These aids and services shall include, but is not limited to, qualified sign language interpreters, audio-description services, alternative format documents and forms in large print and Braille, videotext displays, Video Relay Interpretive services, telecommunications devices and NexTalk.

Consumer - An adult with a diagnosis of mental illness as defined in 59 Ill. Adm. Code 132 who is receiving DMH funded residential services.

Code - The Mental Health and Developmental Disabilities Code [405 ILCS 5].

Confidentiality Act - The Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110].

Day - Calendar day unless otherwise noted.

Department or DHS - The Department of Human Services.

DMH - The DHS Division of Mental Health.

Employee - Any person working or volunteering directly with a consumer at the direction of the provider. This includes anyone providing direct care included on the provider agency payroll, contractors, interns, and volunteers regardless of number of hours or schedules worked or volunteered.

HIPAA - The Health Insurance Portability and Accountability Act (42 USC 1320 et seq.) (45 CFR 160 and 164 (2003)).

HITECH - Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), P.L. 111-5 (Feb. 17, 2009).

Institute for Mental Diseases - A hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services and as defined by Title XIX of the Social Security Act.

**Comment [MSP4]:** Change to "PROVIDER" here and it other places. ACCEPTABLE. Submit during PUBLIC COMMENT period.

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Licensed Practitioner of the Healing Arts or LPHA - See 59 Ill. Adm. Code 132.

Mental Health Professional or MHP - See 59 Ill. Adm. Code 132.

Medical Necessity or Medically Necessary - See 59 Ill. Adm. Code 132.

Missing Person - A consumer whose general whereabouts the provider doesn't know. A consumer who is not in the residence as expected. (COMMENT: DOES THIS DEFINITION PLACE A REQUIREMENT ON THE PROVIDER TO KNOW WHERE THE CONSUMER IS AT ALL TIMES? IF A CONSUMER, ACCORDING TO TREATMENT PLAN, GOES OFF-SITE INDEPENDENTLY, IS THE PROVIDER REQUIRED TO DETERMINE THE CONSUMERS LOCATION?)

Night of Care - A 24 hour period of time during which a consumer is occupying a bed in a residential site at 11:59 p.m.

Notice of Violation - A report submitted to a provider by the Bureau of Accreditation, Licensure and Certification (BALC) listing the deficiencies with this Part noted during a certification survey.

Physical Accessibility - A site, building, facility, or portion thereof deemed accessible in accordance with Americans With Disabilities Act (ADA) (42 USC 12101), as amended, current Department of Justice (DOJ) ADA Standards for Accessible Design, Environmental Barriers Act (EBA) [410 ILCS 25], as amended and ADA Title II/III applicable standards, section 504 of the Rehabilitation Act of 1973 (29 USC 794), as identified within the Illinois Accessibility Code, 71 Ill. Adm. Code 400 and/or ADA Accessibility Guidelines, whichever is more stringent. DHS may require specific reasonable modifications to meet the needs of customer served at a particular site as reviewed on a case-by-case basis.

Plan of Correction - A written plan submitted by a provider to BALC in response to a notice of violation. The plan shall comply with the protocol established by BALC.

Provider – An organization certified to provide Supervised Transitional residential level of care in accordance with this Part that is a sole proprietorship, partnership, limited liability corporation or corporation, public or private, either for profit or not for profit.

**Comment [MSP5]:** The designation of SUPERVISED Residential and the acuity need for admission implies that the consumer requires 24/7 supervision. To not know where consumer is during these periods of supervision implies that the consumer is not in fact being supervised or in need of that level of care. If the consumer leaves the facility as part of the treatment plan the provider is aware of that consumer's location

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Qualified Interpreter - A licensed interpreter who is able to interpret effectively, accurately and impartially both receptively and expressively, using any necessary specialized vocabulary, as licensed according to the Interpreter Licensure Act of 2007.

Qualified Mental Health Professional or QMHP - See 59 Ill. Adm. Code 132.

Rehabilitative Services Associate or RSA - See 59 Ill. Adm. Code 132.

Section 504 of the Rehabilitation Act - Protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any federal department or agency. Section 504 forbids organizations and employers from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services. It defines the rights of individuals with disabilities to participate in, and have access to, program benefits and services.

Site - Any building, under one continuous roof, including, but not limited to houses, apartment buildings, and duplexes in which a consumer(s) receiving a residential level of care lives We assert our interest in maintaining the aggregate number of residential/housing stock but not necessarily all those #S as under current classifications. (COMMENT: SOME FACILITIES HAVE OPERATED AS SUPERVISED RESIDENTIAL SETTINGS IN THE PAST AND MAY NOT BE ABLE TO MEET THIS CRITERIA. IT MAY NOT BE POSSIBLE TO RETROFIT BUILDINGS. WHAT CAN BE DONE TO INSURE THAT THIS PROGRAM CAPACITY IS NOT LOST TO THE TREATMENT SYSTEM? IT IS RECOMMENDED THAT THE DIVISION CONSIDER A WAIVER PROCESS THAT PERMITS EXISTING PROGRAM STRUCTURES TO CONTINUE. IN ORDER TO PRESERVE CURRENT SYSTEM CAPACITY.)

Staff – Persons who meet the requirements for Qualified Mental Health Professional, Mental Health Professional or Rehabilitative Services Associate under 59 Ill. Adm. Code 132 and who are paid by the provider to provide a residential level of care.

Supports - Activities including but not limited to behavioral interventions and assistance with activities of daily living, for which the consumer needs reminding, prompting, or coaching, that cannot be claimed as Rule 132 services and are included as part of the per diem rate expenses for each residential level of care. (COMMENT: IS THE CONCEPT OF “SUPPORTS” BROADER THAN “INTERVENTIONS CONCERNING ADLS”?)

**Comment [MSP6]:** The definition of 'site' does need to be modified.

DMH wishes to be clear that it expects, that because of acuity of consumer need for entry into Supervised Residential, that the "site" should reflect characteristics to adequately respond to the needs of the consumer.

The site should afford all participating consumers individual living quarters as defined in Rule with communal facilities for food, recreation and care all within the same distinct section or unit in which all admitted consumers at the same time can receive supervision through the physical presence of, at the minimum one, staff member.

Current sites not meeting the new Rule's requirement will likely convert to other levels of care/housing designation

**Comment [MSP7]:** KEEP per diem

**Comment [MSP8]:** Supports which aren't in rule 132 as stated

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DO SUPPORTS INCLUDE THOSE INTERVENTIONS CONSISTENT WITH

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COMMUNITY SUPPORTS AS DEFINED IN RULE 132? WHICH RESIDENTIAL STAFF PROVIDE SUPPORTS? RSAs? MHPs? QMHPs?)

Survey - A process to determine a provider's compliance with this Part as described in Section 40 of this Part. The process may include surveyor observation, on-site examination of the following: consumer records, provider policies and procedures, written documentation of implementation of policies and procedures, written documentation of supports provided, desk reviews, and onsite inspection of certified sites. Interviews with employees may also be part of the survey.

Written contingency plan - A plan developed by a provider in preparation for possible emergency situations including but not limited to fires, tornadoes, earthquakes, illnesses or floods that addresses the care and protection of residents.

**Comment [MSP9]:** I would think NO since we are previously stating "that cannot be claimed as Rule 132"

**Comment [MSP10]:** Since these aren't 132 services as defined above seems that any level staff could perform since it is included into the per diem not a FFS

**Section 140.30 Provider Qualifying Conditions**

- a) Applicants must be certified to provide 59 Ill. Adm. Code 132 (Part 132) services.
- b) For recertification under this Part, providers must be certified to provide Part 132 services.
- c) Providers certified under this Part must be accredited within one year of initial certification by one of the following organizations using its residential or housing services standards and maintain that accreditation in order to continue to be certified:
  - 1) 2012 Hospital Accreditation Standards (The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 2006);
  - 2) 2012 Standards for Behavioral Health Care (The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 2006);
  - 3) Council on Accreditation Standards, Eighth Edition (Council on Accreditation of Services for Families and Children (COA), 120 Wall Street, 11<sup>th</sup> Floor, New York, New York 10005, 2012);

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- 4) Quality Outcomes 2012 (The Council on Quality Leadership, 100 West Road, Suite 406, Towson, Maryland 21204, 2005);
- 5) Standards Manual and Interpretive Guidelines for Employment and Community Services (Commission on Accreditation of Rehabilitation Facilities (CARF), 4891 East Grant Road, Tucson, Arizona 85711, 2012);
- 6) Standards Manual and Interpretive Guidelines for Behavioral Health (Commission on Accreditation of Rehabilitation Facilities (CARF), 4891 East Grant Road, Tucson, Arizona 85711, 2012); or
- 7) Healthcare Facilities Accreditation Program (HFAP), (2008 Accreditation Requirements for Mental Health Centers, 142 E. Ontario Street, Chicago, IL 60611).

**Section 140.35 Application and Initial Certification**

- a) Applicants wishing to provide ~~one or more the~~ residential levels of care as defined in Sections 140.215 ~~or 140.220~~ shall apply to DHS for certification. Part of the certification process is the certification of specific sites to be used for the provision of ~~the~~ residential levels of care.
- b) Applications may be obtained by submitting a request in writing to:  
  
Illinois Department of Human Services  
Bureau of Accreditation, Licensure and Certification  
401 N. 4<sup>th</sup> Street  
2<sup>nd</sup> Floor, Room 205  
Springfield, IL 62702
- c) The applicant shall submit to DHS a completed “Application for Certification of Community-Based Residential Levels of Care” with all of the required accompanying components, as specified on the application form.
- d) The application shall include, but not be limited to the following information:

**Comment [CAC11]:** ACCEPT this change during PUBLIC COMMENT period if not already modified during DHS review.

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- 1) Applicant name and corporate status;
  - 2) Description of how the provider will provide the residential level(s) of care as described in this Part that the applicant is intending to provide;
  - 3) Description of population to be served in the residential level;
  - 4) List of sites to be certified and the specific residential level of care proposed to be provided at each site, including accessibility provisions (a site may only have one residential level of care);
  - 5) Fire clearances for each site to be certified that may include a fire clearance from the Office of the State Fire Marshal (OSFM) that is less than one year old obtained for the purpose of Part 132 certification if the OSFM inspection was of the residence portion of the building;
  - 6) Policies on confidentiality, consumer rights and third-party payments;
  - 7) Staffing plan; and
  - 8) An Illinois State Police fingerprint-based background check report and documentation of checks of the Illinois Department of Children and Family Services' State Central Register and Illinois Sex Offender Registry for the owner(s), as applicable, Chief Executive Officer, and Chief Financial Officer.
- e) If the application form and all of the required components are in compliance with this Part, DHS shall issue to the provider a certificate to provide one or more community-based residential levels of care at specific certified sites.
- 1) An applicant that submits an application that is not in compliance with this Part shall receive a Notice of Deficiencies. DHS shall issue the Notice of Deficiencies within 30 days after receiving the application. If the applicant intends to proceed with applying for certification, the applicant shall submit, within 30 days of the date on the Notice of Deficiencies, corrected documentation that addresses all of the deficiencies noted in the

**Comment [MSP12]:** ACCEPT this change as in COMMENT #11. ACCEPTABLE.  
Submit during PUBLIC COMMENT period.

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Notice of Deficiencies. The applicant shall submit the corrected

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documentation to DHS.

- 2) DHS shall issue a certificate within 30 days after it receives the completed application and all required components, including corrected documentation, if applicable. The effective date of certification shall be the date that the application or, if required, corrected documentation is approved.
  - 3) If the applicant fails to submit corrected documentation that demonstrates compliance with this Part within 30 days of the date of the Notice of Deficiencies, DHS shall issue a notice of non-certification.
  - 4) The applicant may reapply by submitting a complete application packet to DHS.
  - 5) When a decision is made to deny certification, the applicant may appeal the decision and request a hearing in accordance with Section 140.65 of this Part and Section 10-25 of the Illinois Administrative Procedure Act [5 ILCS 100/10-25].
- f) Initial certification shall be for 12 months. Within that 12 month period, DHS shall conduct an on-site review to assure compliance with this Part. If an on-site review does not occur during the first 12 months, the initial certification will continue until a review is done and a decision is made on continuing certification.
  - g) If the initial on-site review finds that the provider is compliant at a Level 1 or 2 compliance level as described in 140.60, certification shall be renewed for three (3) years.
  - h) If the initial on-site review finds that the provider is not compliant at a Level 1 or 2 compliance level, certification will not be renewed.
  - i) Any changes during the certification period that affect the ability of the provider to deliver one or more residential levels of care in compliance with the requirements of this Part shall be reported to DHS within 30 days.

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**Section 140.40 Continued Certification and Recertification Determination**

- a) For all providers with three (3) year certification periods, DHS shall conduct at least one on-site survey within the period of certification.
  - 1) During the survey, DHS shall evaluate the provider's compliance with this Part.
  - 2) If no deficiencies are noted during the survey, DHS shall notify the provider of the results within 30 days after the completion of the survey.
  - 3) If deficiencies are noted during the survey, DHS shall report those deficiencies to the provider during an exit conference. DHS shall also issue a Notice of Deficiencies to the provider within 30 days after the completion of the survey.
  - 4) If DHS issues a Notice of Deficiencies to the provider, the provider shall respond with a Plan of Correction as required in Section 140.60 pursuant to requirements of DMH. The Plan of Correction shall address all of the deficiencies listed on the Notice of Deficiencies. The provider must submit this Plan of Correction to DHS by the due date listed on the Notice of Deficiencies.
    - A) Providers that submit a Plan of Correction approved by DHS shall be notified of the approval. DHS shall notify the provider of the approval within 30 days after it receives the provider's Plan of Correction. DHS shall verify the provider's implementation of the Plan of Correction at the next survey. If a Plan of Correction was required per Section 140.60, the next survey shall occur within 14 months after the date the Plan of Correction was approved.
    - B) If a provider submits a Plan of Correction that does not address the deficiencies noted during a survey, DHS shall notify the provider within 30 days after receipt of the provider's Plan of Correction. The provider shall submit a revised Plan of Correction that addresses the deficiencies within 10 days of the date of the

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notification. DHS may revoke the provider's certification if the provider fails to submit an acceptable Plan of Correction.

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- C) DHS may revoke a provider's certification if the provider fails to submit a Plan of Correction by the due date listed on the Notice of Deficiencies.
- 5) Regardless of level of compliance, if any of the following are found during an on-site survey, corrections must be made or there must be an approved plan for corrections specific to the finding provided to and approved by the surveyor(s) prior to the end of the survey, or the provider's written contingency plan must be implemented before the survey is concluded in order for certification to continue or be renewed.
  - A) OIG findings of abuse/egregious neglect/exploitation and the staff person still works for the provider;
  - B) Extreme heat at a site;
  - C) Extreme cold at a site;
  - D) Utility(ies) or telephone not functioning;
  - E) When foods are prepared and served by the provider, spoiled food in refrigerator or outdated food on shelves;
  - F) Lack of food based on consumer input and level of need and reasonable for basic survival foodstuffs;
  - G) Smoke detectors not working, no fire extinguisher;
  - H) More than 16 individuals living at any one site;

(THIS IS A REQUIREMENT THAT SOME EXISTING FACILITIES MAY NOT BE ABLE TO MEET -AND ARE UNABLE TO CHANGE IN A COST-EFFICIENT WAY IN ORDER TO MEET THIS REQUIREMENT. IF

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THE DIVISION WISHES TO PRESERVE CURRENT SYSTEM CAPACITY AND PROTECT THE SIGNIFICANT INVESTMENTS THAT HAVE BEEN

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MADE BY DEVELOPERS AND/OR COMMUNITY AGENCIES, A WAIVER OR “GRAND-FATHER” CLAUSE IS NEEDED FOR SELECTED PROGRAM SITE OR THE PROGRAM IS MOVED TO ANOTHER LEVEL OF RESIDENTIAL CARE (I.E., SUPPORTED RESIDENTIAL).

I) More than 2 individuals sharing a bedroom;

(SOME PROGRAMS MAY NOT BE ABLE TO ADJUST BEDROOM ARRANGEMENTS AND MAINTAIN FINANCIAL VIABILITY. EITHER AN ADJUSTMENT TO FUNDING OR A WAIVER OF THIS REQUIREMENT IS NEEDED FOR SOME PROGRAMS).

J) Evidence of infestation by insects or rodents; or

K) An individual who has a mobility disability living in an inaccessible site; or

L) Failure to provide individuals who are blind, deaf and/or hard-of-hearing with qualified interpreters, auxiliary aids and services, or printed and audiovisual materials in a format that will enable them to have equal access to the information.

b) Compliance surveys for recertification shall be conducted on or about the expiration date of the current certification period. If DHS fails to conduct a compliance survey for recertification before the expiration of the current certification period, the current certification shall remain valid until completion of the compliance survey. Subsequent compliance reviews shall follow the process outlined in Section 140.40(a).

c) DHS shall be granted access to all certified sites. All records shall be made available to DHS on request during the initial on-site survey, recertification surveys, post payment reviews and any other compliance reviews for residential

**Comment [MSP13]:** Because of the clinical needs required for admission to this LOC. It is not DMH's intent to support facilities in excess of 16 beds. See also COMMENT #6 above

**Comment [MSP14]:** Current sites not meeting the new Rule's requirement will likely convert to other levels of care/housing designation.

**Comment [MSP15]:** Current sites not meeting the new Rule's requirement will likely convert to other levels of care/housing designation.

**Comment [CAC16]:**  
This requirement received concurrence during previous stakeholder discussion. Workgroup discussions agreed that no one should have to share a bedroom with more than one person. Generally, we preferred private bedrooms, but compromised at this.

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care delivered under this Part. Access to records shall occur in accordance with the Confidentiality Act [740 ILCS 110], the HIPAA Act (42 USC 1320 et seq.)

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(45 CRR 160 and 164 (2003)) and the HITECH Act (P.L. 111-5 (Feb. 17, 2009)).

- d) When a decision is made to deny recertification of a provider or any of its sites, the provider may appeal the decision and request a hearing in accordance with Section 140.65 of this Part and Section 10-25 of the Illinois Administrative Procedures Act [5 ILCS 100/10-25].

**Section 140.45 Certification of Additional Sites**

- a) Following initial certification, providers that seek certification for additional sites shall submit the following documentation to DHS:
  - 1) A clearance letter from the Office of the State Fire Marshal or approved local fire authority, dated within the preceding 12 months, stating that each additional site complies with local and State fire safety ordinances and codes. The clearance letter must come from the Office of the State Fire Marshal or a local fire inspector trained in inspections and codes by the OSFM.
  - 2) A description of the level of residential care that will be provided at the site, as well as provisions for accessibility.
  - 3) A statement of concurrence from the DMH region for adding the site.
- b) Prior to approval, DHS shall physically inspect all sites to assure that they comply with this Part.

**Section 140.50 Revocation of Certification**

DHS may issue a written notice revoking provider certification during a certification period for any of the following (a) through (i).

- a) The provider is not complying with the Department's policy or rules, or with the terms and conditions prescribed by the Department in its provider agreement and

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refuses or has not agreed to make corrections;

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- b) The provider refuses to permit or participate in a scheduled or unscheduled survey;
- c) The provider violates records requirements by failing to keep or make available for inspection, audit or copying (including photocopying) records required to be maintained by this Part or necessary to fully demonstrate compliance with this Part;
- d) The provider has not kept records up to date that are required to be maintained by the Department regarding payments claimed for providing the funded residential level(s) of care;
- e) The provider has submitted claims-expenses for residential level(s) of care that were not delivered by the provider;
- f) The findings at the next review indicate that the provider has failed to implement a Plan of Correction, as evidenced by less than 50% of the items on the Notice of Deficiencies improving in their compliance percentage;
- g) The findings at the next review indicate that the provider shows a consistent failure to correct deficiencies and maintain those corrections by scoring 74% or less during two consecutive recertification reviews;
- h) The provider willfully violates any rights of consumers being served; or
- i) The Chief Executive Officer, the Chief Financial Officer, or an owner(s) of a for profit provider, is found by OIG or other investigative or legal authority to have abused, financially exploited or egregiously neglected a consumer or is convicted of a crime involving moral turpitude.

**Comment [MSP17]:** LIKELY TO ACCEPT if submitted during PUBLIC COMMENT period.

**Comment [MSP18]:** KEEP as CLAIMS; we are not paying off expenses.

When a notice of revocation has been issued, the provider shall work cooperatively with DMH to assure that consumers are safely and appropriately placed.

**Section 140.55 On-Site-Post Payment Review**

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DMH may conduct on-site ~~post-payment~~ reviews to determine compliance with requirements of

**Comment [CAC19]:** This is specific to post payment reviews. It is not any other kind of review.

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this Part for residential level(s) of care ~~billed~~ expenses and to determine amounts subject to ~~recoupment grant funds recovery~~.

**Comment [MSP20]:** KEEP as IS. We are moving to per diem which are not paid related to expense. KEEP "billed" & keep recoupment.

- a) DMH shall compare ~~billed~~ expensed nights of care to documentation of the delivery of those nights of care made available to it by the provider. DMH will consider expenses ~~claims~~ unsubstantiated when the provider cannot demonstrate that a night of care was provided as defined in this Part.
- b) DMH will report its findings to the provider within 30 days of the review through a Notice of Unsubstantiated expenses ~~Billings~~, service documentation which will identify the ~~claims~~ expenses that were found not to be documented and for supports provided that were not compliant with this Part,
  - 1) The provider will have 30 days after the receipt of the notice to submit a plan to address the compliance problems identified during the post-payment review.
  - 2) DMH shall verify the provider's implementation of the plan.
- c) If it is determined that expenses less than 90% of the billings reviewed are unsubstantiated, DMH will also submit to the provider a Notice of Suspension from Billing within 30 days of the review.
  - 1) When a provider receives a Notice of Suspension ~~from Billing, the provider shall immediately stop submitting bills for community based residential supports as defined in this Part.~~
  - 2) ~~The~~ the provider will have 30 days to make corrections to its documentation processes to bring them into compliance with this Part.
  - 3) When the provider notifies DMH in writing that they have made the necessary corrections, DMH will review them within 14 days of receipt of notification.
  - 4) If compliant, the provider will be notified that the suspension ~~from billing~~

**Comment [MSP21]:** All "expense" reference not acceptable as in COMMENT #20 above

**Comment [MSP22]:** Billing reflects only a single data feature of 'occupied beds', a statistic that should be easily identified and routinely correct such that errors would be significantly infrequent. KEEP as 90%

**Comment [CAC23]:** This post payment review is specific to residential – has nothing to do with 132 – and the suspension of billing is only for residential nights per the per diem billing.

**Comment [MSP24]:** ACCEPT if submitted during PUBLIC COMMENT period.

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has been lifted, ~~and that the provider may resume billing.~~

**Comment [MSP25]:** KEEP as IS. See COMMENT #20

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5) ~~Once suspension from billing is lifted, the provider may submit bills that have the required documentation for supports provided during the suspension.~~

**Comment [CAC26]:** KEEP as IS. This means that if they have the documentation that consumers were being served in the residential program during the suspension, they could bill for those nights when the suspension is lifted. We have the same language in Rule 132.

⊕ DMH may recover funds based upon the findings of the ~~on-site post-payment~~ review in residential levels of care funded through ~~capacity grant funding fee for service.~~ DMH may use the findings of the ~~on-site post-payment~~ review to ~~determine extrapolate~~ the amount of funds to be recovered ~~based on non-allowable expenses, to the total bills from which the sample was drawn when the sample is statistically valid.~~

**Comment [MSP27]:** Keep either as FFS not Capacity Grant

**Comment [MSP28]:** KEEP extrapolate and AS is .

ed) The provider may appeal the DMH intent to recover funds as specified in Section 140.65.

Same language as in Rule 132 and HFS standards.

DMH's action to initiate this option would be published well in advance of implementation.

**Section 140.60 Compliance with Certification Requirements**

Residential level of care providers shall be recognized according to levels of compliance with standards as set forth in this Part. Providers with findings of Level 1 and 2 will be considered to be in good standing with the Department. The levels of compliance are:

- a) Level 1 – Compliant (90-100% compliance): No written Plan of Correction will be required of the provider.
- b) Level 2 – Substantial compliance (75-89% compliance): A Notice of Deficiencies is issued. The provider shall submit a written Plan of Correction to address the identified deficiencies. Within 12 months after the date that a Plan of Correction is approved, DHS shall conduct a review to evaluate the provider's implementation of the Plan of Correction. If the provider fails to submit and implement a Plan of Correction within the designated time frame, DHS may revoke the provider's certification to provide supports pursuant to this Part.
- c) Level 3 – Minimal compliance (50-75% compliance): A Notice of Deficiencies is issued. The provider shall submit a written Plan of Correction to address the identified deficiencies. After 90 days from the date that a Plan of Correction is

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approved, DHS shall conduct a review to evaluate the provider's implementation of the Plan of Correction. The provider's level of compliance must reach at least

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Level 2 to demonstrate implementation of the Plan of Correction. If the provider fails to submit and implement a Plan of Correction within the designated time frame, DHS may revoke the provider's certification to provide supports pursuant to this Part.

- d) Level 4 – Unsatisfactory compliance (under 50% compliance): A Notice of Deficiencies is issued. The provider shall submit a written Plan of Correction to address the cited deficiencies. After 60 days from the date that a Plan of Correction is approved, DHS shall conduct a review to evaluate the provider's implementation of the Plan of Correction. The provider's level of compliance must reach at least Level 3 to demonstrate implementation of the Plan of Correction. After 90 days from the date that the Plan of Correction was approved, the provider's level of compliance must reach at least Level 2 to demonstrate implementation of the Plan of Correction. If the provider fails to submit and implement a Plan of Correction within the designated time frames, DHS may revoke the provider's certification to provide supports pursuant to this Part.

**Section 140.65 Appeal of Denial of Certification or Recertification, Revocation and ~~On-Site Post Payment Review Findings~~**

**Comment [MSP29]:** AS in COMMENT 19 above.

- a) If DHS determines that the provider is not in compliance with the requirements of this Part pursuant to certification or ~~an on-site a post payment~~ review and takes action to deny certification, revoke certification, suspend certification or recoup funds, DHS shall notify the provider in writing of its findings. The notice shall include:

**Comment [CAC30]:** This is relevant only to post payment reviews.

- 1) The reason for the DHS action;
- 2) A statement of the provider's right to request a hearing within 20 days after the provider's receipt of the written notice;
- 3) A statement of the legal authority and jurisdiction under which the hearing is to be held; and

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- 4) The address where a request for hearing may be filed.
- b) If a provider chooses to appeal the DHS findings, the provider shall submit a written request for a hearing to DHS within 20 days after the date of receipt of the written notice. The appeal shall specify the grounds for the appeal.
- c) The request for hearing shall be filed with, and received by, DHS within 20 days after the date of the receipt of the written notice to the provider.
- d) Hearings shall be conducted in compliance with 89 Ill. Adm. Code 508.
- e) The Secretary of DHS shall issue a final administrative decision in accordance with the provisions of 89 Ill. Adm. Code 508.
- f) The final administrative decision shall be subject to judicial review exclusively as provided in the Administrative Review Law [735 ILCS 5/Art.III].
- g) In cases of appeal of ~~on-site post payment~~ review findings, a provider shall be liable for reimbursement of any capacity grant funds paid to the provider for services provided within the level of residential services ~~claims submitted from the date of the final administrative decision if such decision results in an adverse finding for the provider.~~

**Comment [CAC31]:** This again is the same language as in Rule 132 and pertains only to post payment reviews.

**Section 140.70 Utilization Management**

- a) ~~The AH~~ community-based residential levels of care specified in Section 140.215 ~~is are~~ subject to utilization management by DMH based on the following criteria:
  - 1) The definition of medical necessity in 59 Ill. Adm. Code 132;
  - 2) The type, severity and chronicity of the consumer's symptoms;
  - 3) The severity of impairment in the consumer's role functioning;
  - 4) The risks that a consumer's symptoms or level of role functioning pose to the safety of the consumer or to others with whom the consumer interacts;
  - 5) The expected short-term and long-term outcome of the residential level of care needed by the consumer;

**Comment [MSP32]:** ACCEPTABLE. Submit during PUBLIC COMMENT period.

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- 6) Progress made in response to treatment, if the consumer is currently

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receiving treatment;

- 7) Criteria or guidance published by DMH for the purposes of defining and evaluating the medical necessity of residential levels of care; and COMMENT #1: WHERE WILL THIS CRITERIA OR GUIDANCE BE PUBLISHED? IN THE DMH PROGRAM MANUAL? IT IS RECOMMENDED THAT THE PROPOSED RULE INCLUDE THE DOCUMENT OR GUIDANCE BY REFERENCE OR TIED TO CONTRACT DOCUMENTS.  
COMMENT #2: IF SOMEONE IS NO LONGER DETERMINED TO "NEED" RESIDENTIAL LEVEL OF CARE, WHAT HAPPENS TO THEM? ARE THEY DISCHARGED? TO WHERE?

**Comment [CAC33]:** Not developed yet. Would be published on DMH webpage prior to use. Would most likely be presented in training.

- 8) Available funding.

**Comment [MSP34]:** This is dealt with in 140.110 a6 and e BELOW

- b) DMH may perform utilization management reviews using the standards in Subpart C for determining the level of residential care. DMH shall **conduct and** notify the provider of the finding of the utilization management review within five (5) days of the submission of the authorizations/reauthorization.

**Comment [MSP35]:** This dealt with in " c" below

- c) DMH shall notify the provider of the findings of the utilization management review within five (5) days of the review. (ARE THE STANDARDS IN SUBPART C, SECTION 140.210 OR SECTION 140.215? OR BOTH?)

- d) -If DMH denies the reconsideration request of the provider, the provider may appeal to the Secretary of DHS within 5 days of the receipt of denial.

**Comment [CAC36]:** 140.65 is the section that addresses all appeals.

- ee) If the review finds that the level of residential care being provided is not appropriate to the needs and choices of the consumer, DMH may require an appropriate transition plan that incorporates the consumer's choice in living ~~A~~arrangements, ~~choosing from from those services available, -affordable and for which the consumer is eligible, - and may cease payment for that level of residential care not found appropriate.~~ Can we add that the consumer will never be discharged into homelessness?

**Comment [MSP37]:** KEEP AS is. Seems to be detail not needed.

**Comment [MSP38]:** NOT appropriate for RULE language

- d) If DMH and the provider do not concur on medical necessity, the provider may

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request reconsideration of the decision in writing within 30 days of the review to DMH, specifying the grounds for the reconsideration. The provider may submit additional supporting evidence or documentation for the reconsideration. During the reconsideration, the consumer may continue to receive residential care that will be funded by DMH.

- e) The reconsideration request shall be reviewed within 14 days of receipt of the reconsideration request.
- f) If DMH denies the reconsideration request of the provider, the provider may appeal in writing within 5 days of the date of the denial to the Secretary of DHS. No additional evidence or documentation may be provided for the appeal.
- g) The Secretary shall issue a final administrative decision regarding the appeal.
- h) The final administrative decision shall be subject to judicial review exclusively as provided in the Administrative Review Law [735 ILCS 5/Art. III].
- i) If an appeal is filed, the consumer may continue to receive residential care that will be funded by DMH during the appeal process.
- j) If the finding of the final appeal agrees that the specific residential level of care is not medically necessary, the provider must inform the consumer of the finding and work with the consumer to make an informed choice about continuing that residential level of care with non DMH funding or receiving a different medically necessary residential level of care or alternative housing option.

**Section 140.75 – Rate Setting Capacity Grant Funding**

- a) ~~DMH shall compute rates of reimbursement per night of care for residential levels of care defined under this Part based on the number of beds for which the site is certified. Providers and the public shall be informed of any changes in the methods and standards of determining payment rates for residential levels of care funded under this Part.~~

**Comment [MSP39]:** KEEP all DMH original language. No references to CAPACITY grant are indicated.

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- a) ~~b)~~ DMH shall calculate rates on a per diem basis considering the following factors:
  - b) ~~—~~
  - e) ~~1) Reasonable costs for staff required under Sections 140.215 and 140.220 net of expected billing by staff for services defined in 59 Ill. Adm. Code~~
  - d) ~~132;~~
  - e) ~~—~~
  - f) ~~2) The number of beds certified for each residential level of care site;~~
  - g) ~~—~~
  - h) ~~3) The residential level of care for which the site is certified;~~
  - i) ~~—~~
  - j) ~~4) Reasonable costs for room and board; and~~
  - k) ~~—~~
  - l) ~~5) The efficient operation of residential sites based on economies of scale.~~
  - m) ~~—~~
  - n) ~~e) a)~~ DMH shall pay for residential levels of care on a capacity grant funding basis.  
Capacity grant funding shall meet the following guidelines: per diem basis for each night of care provided to a qualifying consumer based upon the following conditions:
  - o) ~~—~~
  - p) ~~1) The residential level of care rate for the certified residential site in which the consumer is staying; and~~
  - q) ~~—~~
  - r) ~~2) Deductions based upon other sources of payment to the provider or landlord as follows:~~
  - s) ~~—~~
  - t) ~~A) 30% of the consumer's SSI (Supplemental Security Income); and~~
  - u) ~~—~~
  - v) ~~B) United States Department of Housing and Urban Development (HUD) rent subsidies and rent subsidies paid by local, county or State government.~~
- b)
- 1) The ratio of expenditures for the delivery of services and related activities to administrative costs shall be in accordance with the standards established in the Community Services Agreement and the Department of Human Services Division of Mental Health -Provider Manual.

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- 2) DHS/DMH shall establish a method for calculating the amount of reimbursement from Medicaid mental health services per residential site. This amount shall be established as a portion of reimbursement for the residential services.
- 3) DHS/DMH will specify any additional reporting requirements.

**Comment [MSP40]:** NOT ACCPETABLE.  
DMH rates are expected to support payment in full for the residential services as defined.

**Comment [MSP41]:** ACCEPTABLE.  
Submit during PUBLIC COMMENT period.

**Section 140.80 Non-transferability of Certificate**

- a) A certificate granted pursuant to this Part is not assignable or transferable.
- b) Discontinuation of operations causes the certificate to be void.
- c) Certificate documents and all copies shall remain Department property and shall be returned by the provider within 10 days after notifying the Department of a change in ownership, or if the certificate is revoked or modified.

**Section 140.85 Cessation of Operations**

- a) If, at any time, a provider determines that it will terminate operation or close a site, it shall notify DMH in writing of its decision at least 60 days prior to the date of termination. In the event of a disaster (e.g. fire, storm damage) which renders a site unable to be occupied, the provider shall immediately notify DMH verbally and in writing. In both instances the provider will submit a written transition plan for the consumers within five days.
- b) Said notices shall be given to DMH, to other providers working with all affected consumers, and to any consumer who must be temporarily moved, transferred or discharged, and to the consumer's guardian, when applicable.
- c) The notice shall state the proposed date for cessation and the reason.
- d) The provider shall work cooperatively with DMH to assure that consumers are safely and appropriately placed in residential level(s) of care prior to cessation of operations.
- e) DMH will continue to pay the provider for services delivered during closure as long as the services continue to be provided in compliance with this Part.

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**SUBPART B: PROVIDER ADMINISTRATIVE REQUIREMENTS**

**Section 140.100 Organizational Requirements**

a) Staffing

- 1) Provider employees shall be licensed or certified in accordance with Illinois law. COMMENT: DOES THIS MEAN THAT ALL PROVIDER EMPLOYEES SHALL BE LICENSED OR CERTIFIED?
- 2) The provider shall employ sufficient residential employees to address the needs of the consumers for whom it is providing residential levels of care per the consumers' assessed needs. COMMENT: HOW SHALL PROVIDERS DETERMINE "SUFFICIENT STAFFING"? IS THERE A RATIO OF STAFF-TO-RESIDENT? IS THERE A MINIMUM STAFF LEVEL? IS THERE A SPECIFIC TYPE OF STAFFING REQUIRED? )
- 3) Employee(s) on duty shall know how to access immediate crisis medical emergency services and psychiatric consultation in order to address emergency needs that may arise.
- 4) The provider shall have written back-up procedures for coverage of employee absences of any kind.
- 5) The provider shall have a QMHP designated as responsible for each consumer receiving residential supports. The QMHP shall provide clinical oversight of residential staff. COMMENT: IS THE QMHP CONSIDERED TO BE A RESIDENTIAL STAFF? THE PROVIDER FUNDED THROUGH CAPACITY GRANTS WILL BE REQUIRED TO REPORT EXPENSES INCURRED WITHIN THE PROGRAM.

**Comment [MSP42]:** NO "KEEP As Is "in accordance with Illinois law"

**Comment [MSP43]:** Agency determines the FTE "as needed" not us via ratios or otherwise

**Comment [MSP44]:** Yes the one RSA per shift on site as stated elsewhere – see 140.215 c1

**Comment [MSP45]:** Yes the one RSA per shift on site as stated elsewhere – see 140.215 c1

**Comment [CAC46]:** When we shift to FFS for supervised residential, there won't be any capacity grant for the same program.

b) General Program Requirements

Provider shall meet the following requirements:

- 1) Abuse and neglect

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- A) The provider shall have and use a process for reporting and handling instances of abuse and neglect that is in accordance with applicable standards, regulations and laws (including 59 Ill. Adm. Code 50) and includes notification of the consumer allegedly abused or neglected and his/her guardian, as applicable, of the allegation within 24-hours after receiving the allegation.
  - B) The provider shall not employ a person in any capacity until the provider has inquired of the Department of Public Health (DPH) as to information in the Healthcare Worker Registry concerning the person. If the Registry has information substantiating a finding of abuse or neglect against the person, the provider shall not employ him or her in any capacity.
  - C) If the person is not listed in the Registry, she or he must be added to the Registry using the process established by DPH.
  - D) The provider shall perform background checks, in compliance with requirements set forth by the Illinois Healthcare Worker Background Check Act [225 ILCS 46], on all persons, paid or unpaid, who provide residential care.
- 2) Admission to Residential Levels of Care
- A) Providers shall not discriminate in the admission to and provision of needed residential levels of care to consumers on the basis of age, sex, race, religious belief, ethnic origin, marital status, gender identification, physical, intellectual or mental disability, or criminal records unrelated to present dangerousness.  
(COMMENT: PLEASE REVIEW HUD GUIDELINES REVISE THIS TO BE CONSISTENT WITH HUD REQUIREMENTS CONCERNING INDIVIDUALS WITH CRIMINAL RECORDS.)
  - B) Admission policies and procedures shall be set forth in writing and be available for review.
  - C) These policies and procedures must be consistent with the general

**Comment [CAC47]:** We'd like to see the specifics to us. Likely this would be irrelevant to this level of care as those HUD locations may be considered to convert to another LOC or housing.

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principles of recovery, treatment in the least restrictive, clinically appropriate setting and with utilization management parameters as established by DMH. (COMMENT #1: WHAT DOCUMENT CONTAINS THE “PRINCIPLES OF RECOVERY”? PROGRAM MANUAL? IT IS RECOMMENDED THAT THE PROPOSED RULE CITE THE DOCUMENT CONTAINING “PRINCIPLES OF RECOVERY”.

COMMENT #2: WHAT ARE THE UTILIZATION MANGEMENT PARAMETERS? IT IS RECOMMENDED THAT THE PROPOSED RULE SITE THE DOCUMENT CONTAINING “UTILIZATION MANAGEMENT PARAMETERS.

**Comment [MSP48]:** On the DMH webpage at <http://www.dhs.state.il.us/page.aspx?item=33530> is the section of the FY14 DHS/DMH Community Provider Manual that is the chapter on the Philosophy of Recovery.

**Comment [MSP49]:** This covered in 140.70 b and 140.120

- D) The provider shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless it can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity in accordance with the Americans With Disabilities Act. The provider shall communicate this policy to all visitors, recipients of services, potential recipients of services, and employees.
- 3) Medication Storage/Safeguarding
    - A) The provider shall develop and implement written policies and procedures for the self-administration and monitoring of medication for consumers.
    - B) Medications will be stored to protect from any unauthorized access.
    - C) Consumers deemed capable of self-administration of medications shall have access to their medications, but those medications must be secured from access by any other consumer.
  - 4) The provider will develop, maintain and implement a policy on tobacco, drug or alcohol use at each site.

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- 5) The provider will develop, maintain and implement a policy on consumer input into residential policies that encourages consumer self-governance of the site in which they receive a residential level of care. (COMMENT: SOME RESIDENTIAL SETTINGS ARE REQUIRED TO MEET HUD GUIDELINES CONCERNING SELF-GOVERNANCE-. WHAT DOES DMH REQUIRE CONCERNING SELF GOVERNANCE AND CONSUMER INPUT?)
- 6) Food Preparation and Storage
- A) When foods are prepared and served by the provider, meals shall be varied, nutritionally appropriate and sufficient for the consumers.
- B) When a physician has prescribed a special diet for a consumer and the provider prepares and serves food, that diet shall be provided.
- C) Meals prepared by the provider shall be prepared under clean and sanitary conditions.
- D) Consumers shall have input to weekly menus when food is prepared and served by the provider.
- E) Consumers shall have access to food and be allowed to prepare or participate in preparation of meals. (COMMENT: WHAT DOES "ACCESS" MEAN-. ESPECIALLY IN LIGHT OF POTENTIAL SPECIAL DIETS FOR SOME CONSUMERS?)
- F) Consumers shall have access to healthy snacks of their choice. (COMMENT: WHAT DOES "ACCESS" MEAN-. ESPECIALLY IN LIGHT OF POTENTIAL SPECIAL DIETS FOR SOME CONSUMERS?)
- c) Employee Training

**Comment [MSP50]:** As stated here, We want an Agency specific policy that outlines what they do.

**Comment [MSP51]:** ACCESS means to "obtain or make use of". Submit during the PUBLIC COMMENT period like if because of consumer specific dietary requirements "except as contraindicated by 6B above."

**Comment [MSP52]:** ACCESS means to "obtain or make use of".

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- 1) A provider of residential levels of care is responsible for the monitoring and supervision of its employees to assess whether the employees are adequately equipped and supported to provide residential care safely in the residential environment. The provider shall ensure that employees have been trained before being allowed to work unsupervised alone with consumers in any residential level of care and that there is a written plan to ensure that employees periodically demonstrate competence in the training areas listed in subsection (c)(2).
- 2) Employees shall demonstrate competence in training areas listed in this subsection as part of an orientation program and as required in the written plan for ongoing competence. Employees without previous experience in providing residential levels of care to consumers with mental illnesses shall receive training and demonstrate competence prior to unsupervised responsibility for the provision of care unless trained employees are on site and available to provide on-the-job training. Employees who have completed training and demonstrated competence in the below mentioned areas in other jobs, as documented in the employee records, shall not be required to repeat that training as part of their orientation. Employees shall periodically demonstrate competence in training areas listed in this subsection. Employees without demonstrated competence shall receive training until they can demonstrate competence in the following areas:
  - A) Principles of recovery and resilience; (COMMENT: WHAT SHALL BE THE SOURCE OF THESE PRINCIPLES? IT IS RECOMMENDED THAT THE DOCUMENT(S) CONTAINING THESE PRINCIPLES [PROGRAM MANUAL?] BE CITED IN THE PROPOSED RULE.)
  - B) Cardiopulmonary Resuscitation (CPR), choking care and first aid;
  - C) Safety, fire and disaster procedures;
  - D) Abuse, neglect handling and reporting per requirements of the DHS Office of Inspector General, 59 Ill. Adm. Code 50 and 59 Ill. Adm. Code 51;
  - E) Individual rights in accordance with Chapter 2 of the Code [405

**Comment [MSP53]:** KEEP alone since the minimum requirements per RULE is one staff 24/7. Just because they are working alone doesn't necessarily mean they are not supervised just not at each every moment.

**Comment [MSP54]:** On the DMH webpage at <http://www.dhs.state.il.us/page.aspx?item=33530> is the section of the FY14 DHS/DMH Community Provider Manual that is the chapter on the Philosophy of Recovery

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ILCS 5/2-100 through 2-202] and maintaining confidentiality in accordance with the Confidentiality Act, the HIPAA Act and the HITECH Act;

- F) Individual rights in accordance with the Americans With Disabilities Act and section 504 of the Rehabilitation Act;
  - G) The type, dosage, characteristics, effects and side effects of medications prescribed for consumers; (COMMENT: WHAT CURRICULUM OF TRAINING SHALL BE USED TO ESTABLISH AN APPROPRIATE BASELINE OF TRAINING CONTENT FOR STAFF? THE TOPIC OF MEDICATIONS, DOASAGE, EFFECTS AND SIDE EFFECTS IS A BROAD SUBJECT. IT IS RECOMMENDED THAT MORE SPECIFICS BE IDENTIFIED OR A TRAINING TOOL BE REFERENCED.)
  - H) Universal precautions;
  - I) Emergency psychiatric crisis intervention techniques;
  - J) Aggression management; and
  - K) Symptoms, behaviors and supportive service needs of persons with serious mental illness.
- 3) The provider must show documentation indicating that all employees have engaged in staff development and education. Acceptable documentation may include, but is not limited to, training approval forms, reimbursement/payments for training, training calendars, outlines of training, or a list of notifications of training events.

(COMMENT: IF THIS PROPOSED REGULATION INCLUDES PROGRAM SITES CURRENTLY CONSIDERED TO BE CILA PROGRAMS [PROGRAM 620] WHAT TRAINING REQUIREMENTS ARE PROPOSED FOR THOSE PROGRAMS? DO THE TRAINING REQUIREMENTS CHANGE WHEN THE PROGRAM IS "RECLASSIFIED" UNDER THIS RULE INSTEAD OF BEING

**Comment [MSP55]:** The broadness is "specified" in "type, dosage, characteristics effects side effects". Language is as in Rule 132.

DMH will not provide a tool. Much of this is likely also considered under your accreditation standards.

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REGULATED BY THE CILA RULE [RULE 115]). IS THERE A STANDARDIZED TRAINING CURRICULUM TO BE RECOMMENDED?

d) Unusual incidents

1) The provider shall have written policies and procedures for handling, investigating, reporting, tracking and analyzing unusual incidents through the provider's management structure, up to and including the authorized agency representative. The provider shall ensure that employees demonstrate their knowledge of, and follow such policies and procedures. Unusual incidents shall include but are not limited to the following:

- A) Sexual assault;
- B) Abuse or neglect;
- C) Death;
- D) Medication errors;
- E) Physical injury;
- F) Assault;
- G) Missing persons;
- H) Theft;
- I) Criminal conduct;
- J) Attempted suicide or suicide; and
- K) Self harm requiring medical intervention.

2) As soon as possible, but within 24 hours after occurrence, the provider shall report any incident which is subject to the Criminal Code of 1961 [720 ILCS 5] to the local law enforcement agencies.

**Comment [MSP56]:** The training standards apply to the LOC – "Supervised Transitional" as applied for and certified.

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- 3) The provider shall ensure that suspected instances of abuse or neglect against consumers receiving residential levels of care are reported to the DHS Office of Inspector General per requirements of 59 Ill. Adm. Code 50.

**Section 140.105 Fiscal Requirements**

- a) Providers shall have modified accrual accounting system in accordance with generally accepted accounting principles (GAAP).
- b) ~~The provider shall submit to DHS Financial Reporting as required by DHS.~~
- ~~c) The provider shall determine and document payment it receives on behalf of the consumer for each night of care provided from sources other than DMH and all rent paid directly by the consumer to a landlord. These sources are:
  - 1) 30% of consumer's SSI;
  - 2) HUD rent subsidies; and
  - 3) Rent subsidies from local, county or State government other than HUD.~~
- d)c) The provider shall accept payment of the DMH rate as payment in full for the residential level of care provided. This means that the total of all payments for a residential level of care from the above sources and from DMH cannot exceed the established rate for any residential level of care.
- e) ~~A provider's established charges to the consumer for a residential level of care may not exceed 30% of the consumer's SSI. This amount must be collected by the provider from the consumer and will be applied toward the rate.~~

The Provider's obligation in receiving capacity grant funds is to expend the funding for allowable expenses required to meet the program's objectives or reconcile with services based on the Provider's contract with the Department and to report to the Department on appropriate deliverables. As it meets the program objectives, a

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Provider may determine that some program activities supported by these grant funds are billable services. However, when a Provider bills for an activity under a capacity grant program, the Provider is not to report the activity or the expenses as part of the grant funded deliverable, as this would result in counting the activity more than once in meeting the Provider's obligation

And, in Rule 132.

=

In the reconciliation of allowable expenses, the Department expects the provider to demonstrate allowable expenses for the total of capacity grant funding for each program, not portions of the award that may be associated with Provider service-sites.

**Comment [MSP57]:** NO reference to Capacity Grant funding is indicated in this Rule.

**Comment [MSP58]:** NO reference to Capacity Grant funding is indicated in this Rule.

**Section 140.110 Clinical Records**

- a) The consumer's clinical record shall contain the following at admission:
  - 1) Identifying information, including consumer's name, Medicaid recipient identification number, address and telephone number, gender, date of birth, primary language and method of communication, name and phone number of emergency contact, name and phone number of primary care physician, admission date, third party insurance coverage, marital status, and source of referral;
  - 2) Documentation of consent for residential level of care;
  - 3) Assessment and reassessment reports;
  - 4) Documentation concerning the prescription and administration of psychotropic medication;
  - 5) Documentation of all medical conditions including food and other allergies; and
  - 6) Provider's self-authorization for placement and continued stay based on assessment criteria developed by DMH. (COMMENT: WHERE WILL THESE ASSESSMENT CRITERIA BE STATED? IN THE

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PROGRAM MANUAL? IT IS RECOMMENDED THAT THE LOCATION OF PUBLICATION OF ASSESSMENT CRITERIA BE IDENTIFIED IN

**Comment [MSP59]:** This is covered in 140.70 b and 140.120. Criteria and interpretative guidelines would be independently published as is the case with the DMH program book and Rule 132 interpretive guidelines so that industry changes to the criteria can be made without proceeding through an elongated Rule making process

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RULE AND REFERENCED AS A PART OF THE PROVIDER'S CONTRACT WITH THE DEPARTMENT.)

- b) The consumer's clinical record shall contain a copy of the current Individual Treatment Plan (ITP) for the provision of treatment.
- c) The consumer's clinical record shall include the following as necessary:
  - 1) Documentation of consumer referral or transfer during the previous twelve (12) months to or from the provider's programs or to or from other providers and the reason for such transfer;
  - 2) A written record of the consumer's major accidents or incidents that occur at the residential site, whether self-reported or observed, and resulting in an adverse change in the consumer's physical or mental functioning;
  - 3) Documentation of nights of care; and
  - 4) Discharge summary, when discharge occurs, documenting the outcome of treatment and the linkages for continued services.
- d) Required records shall be retained for a period of not less than 6 calendar years from the date of service, except that if an audit is initiated within the required retention period the records shall be retained until the audit is completed and every exception resolved. This provision is not to be construed as a statute of limitations.
- e) If the provider ceases to provide Supervised Transitional Residential Level of Care services per 140.85, the provider must make arrangements for the maintenance of records for the full six year period.

**Section 140.115 Sites**

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- a) Sites in which a residential level of care is provided shall not be located in settings that also house institutional ~~services-services~~ (COMMENT: WHAT DOES "INSTITUTIONAL SERVICES MEAN? WHAT ARE THE

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- b) INSTITUTIONAL SERVICES THAT ARE CONTEMPLATED BY THE DIVISION TO BE PROHIBITED?) and shall comply with:
- 1) locally adopted building codes as enforced by local authorities;
  - 2) applicable chapters of the editions of the National Fire Protection Association (NFPA) 101, Life Safety Code as cited in the rules of the Office of the State Fire Marshal at 41 Ill. Adm. Code 100; and
  - 3) all local fire codes that are more stringent than the NFPA and enforced by local authorities or the Office of the State Fire Marshal.
- b) The provider shall make available the report of an inspection that has been made by local fire authorities trained by the OSFM or by the OSFM prior to providing a residential level of care as defined in this Part to any individual in any site.
- c) In addition to meeting the standards in a) above, each site shall also meet the following additional standards:
- 1) Each site shall have a smoke detection system which complies with the Smoke Detector Act [425 ILCS 60].
  - 2) Each site shall have a carbon monoxide detection system which complies with the Carbon Monoxide Alarm Detector Act [430 ILCS 135/].
  - 3) No more than 16 consumers shall reside in any site. (COMMENT: SOME FACILITIES HAVE OPERATED AS SUPERVISED RESIDENTIAL SETTINGS IN THE PAST AND MAY NOT BE ABLE TO MEET THIS CRITERIA. IT MAY NOT BE POSSIBLE TO RETROFIT BUILDINGS. WHAT CAN BE DONE TO INSURE THAT THIS PROGRAM CAPACITY IS NOT LOST TO THE TREATMENT SYSTEM? PLEASE CONSIDER A WAIVER PROCESS THAT PERMITS EXISTING PROGRAM STRUCTURES TO CONTINUE. IF A SITE HAS MORE THAN 16 CONSUMERS UNDER ONE ROOF, IT IS RECOMMENDED THAT A WAIVER PROCESS BE

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ESTABLISHED IN ORDER TO PRESERVE CAPACITY AND CONTINUED OPERATION OF THE SITE OR CONSIDER RE-CLASSIFYING THE SITE AS A "SUPPORTED" RESIDENTIAL SITE. THERE ALSO MAY NEED TO BE A DISTINCTION MADE BETWEEN A SITE WITH A CONGREGATE LIVING ENVIRONMENT VERSES A SITE WITH INDIVIDUAL [UNITS].)

- 4) There shall be documentation that sites are inspected quarterly by the provider to insure safety, basic comfort and compliance with this Part.

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- d) The provider shall have flexible site policies that respect each consumer's right to choice in areas such as mealtime participation, bedtimes, lights out, visitors, and participation in activities outside the site.

- e) Sites shall be required to comply with the following:

- 1) Bath and toilet rooms

- A) At least one bathroom shall be provided for every four consumers. A bathroom shall include a toilet, lavatory, and tub or shower.

(COMMENT: SOME FACILITIES HAVE OPERATED AS SUPERVISED RESIDENTIAL SETTINGS IN THE PAST AND MAY NOT BE ABLE TO MEET THIS CRITERIA. IT MAY NOT BE POSSIBLE TO RETROFIT BUILDINGS. WHAT CAN BE DONE TO INSURE THAT THIS PROGRAM CAPACITY IS NOT LOST TO THE TREATMENT SYSTEM? PLEASE CONSIDER A WAIVER PROCESS THAT PERMITS EXISTING PROGRAM STRUCTURES TO CONTINUE.)

- B) Bathrooms shall be located and equipped to facilitate independence. When needed by the consumer, assistance or devices shall be provided.

- C) Bathing and toilet facilities shall provide privacy that includes doors that are able to be locked from the inside.

- D) All interior doors that are able to be locked shall be able to be

**Comment [MSP60]:** Because of the clinical needs required for admission to this LOC, it is not DMH's intent to support facilities in excess of 16 beds. See also COMMENT #6 above.

Current sites not meeting the new Rule's requirement will likely convert to other levels of care/housing designation.

**Comment [MSP61]:** Because of the clinical needs required for admission to this LOC, it is not DMH's intent to support facilities in excess of 16 beds. See also COMMENT #6 above.

Current sites not meeting the new Rule's requirement will likely convert to other levels of care/housing designation.

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unlocked from the outside in case of emergency.

- 2) Bedrooms:
- A) Each single person bedroom shall have at least 75 square feet of open floor space, not including space for closets, wardrobes, bathrooms and clearly definable entryway areas. (COMMENT: SOME FACILITIES HAVE OPERATED AS SUPERVISED RESIDENTIAL SETTINGS IN THE PAST AND MAY NOT BE ABLE TO MEET THIS CRITERIA. IT MAY NOT BE POSSIBLE TO RETROFIT BUILDINGS. WHAT CAN BE

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DONE TO INSURE THAT THIS PROGRAM CAPACITY IS NOT

B) LOST TO THE TREATMENT SYSTEM? PLEASE CONSIDER A WAIVER PROCESS THAT PERMITS EXISTING PROGRAM STRUCTURES TO CONTINUE.)

- B) Each two-person bedroom shall have at least 55 square feet of net floor area per consumer not including space for closets, wardrobes, bathrooms and clearly definable entry areas. No bedroom shall accommodate more than two consumers.

(COMMENT: SOME FACILITIES HAVE OPERATED AS SUPERVISED RESIDENTIAL SETTINGS IN THE PAST AND MAY NOT BE ABLE TO MEET THIS CRITERIA. IT MAY NOT BE POSSIBLE TO RETROFIT BUILDINGS. WHAT CAN BE DONE TO INSURE THAT THIS PROGRAM CAPACITY IS NOT LOST TO THE TREATMENT SYSTEM? PLEASE CONSIDER A WAIVER PROCESS THAT PERMITS EXISTING PROGRAM STRUCTURES TO CONTINUE.)

- C) Secure storage space for clothing and other personal belongings shall be provided for each consumer.
- D) Each bedroom shall have:

**Comment [MSP62]:** Because of the clinical needs required for admission to this LOC, it is not DMH's intent to support facilities outside this standard. See also COMMENT #6 above.

Current sites not meeting the new Rule's requirement will likely convert to other levels of care/housing designation.

**Comment [MSP63]:** Because of the clinical needs required for admission to this LOC, it is not DMH's intent to support facilities outside this standard. See also COMMENT #6 above.

Current sites not meeting the new Rule's requirement will likely convert to other levels of care/housing designation.

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- i) Walls that extend from floor to ceiling;
- ii) A door that closes and may be locked from the inside.
- iv) If furnished by the provider, the bed shall be suitable to the size and needs of the consumer;
- v) At least one outside window, that is operable; and
- vi) An electrical light or lamp, sufficient for reading.

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- E) Each bedroom shall maintain a dry and comfortable environment.
  - F) In group arrangements, traffic to and from any room shall not be through a consumer's bedroom.
- 3) The provider shall ensure that all sites are compliant with HUD Housing Quality Standards (HQS). (COMMENT: WHAT QUALITY STANDARDS ARE REQUIRED BY HUD QUALITY STANDARDS THAT ARE NOT LISTED ABOVE? IT IS RECOMMENDED THAT THE DESIRED HUD QUALITY STANDARDS BE IDENTIFIED SPECIFICALLY IN RULE, TO ASSURE A CLEAR UNDERSTANDING OF REQUIREMENTS. AGAIN, SOME FACILITIES HAVE OPERATED AS SUPERVISED RESIDENTIAL SETTINGS IN THE PAST AND MAY NOT BE ABLE TO MEET THIS CRITERIA. IT MAY NOT BE POSSIBLE TO RETROFIT BUILDINGS. WHAT CAN BE DONE TO INSURE THAT THIS PROGRAM CAPACITY IS NOT LOST TO THE TREATMENT SYSTEM? PLEASE CONSIDER A WAIVER PROCESS THAT PERMITS EXISTING PROGRAM STRUCTURES TO CONTINUE.)
- 4) The provider shall develop, implement and maintain a disaster preparedness plan that shall be reviewed annually and ensure that:
- A) Records and reports of fire and disaster training are maintained;
  - B) A record of actions taken to correct noted deficiencies in fire and

**Comment [CAC64]:** This statement was added at the specific suggestion of the Rule workgroup stakeholders.

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disaster drills or inspections is maintained;

- C) Employees know and practice how to react to fire, severe weather, disasters, missing persons, psychiatric and medical emergencies, and deaths;
- D) Consumers living in the site(s) know how to react to fire or severe weather or are receiving training;
- E) Employees and consumers are trained in the location of firefighting equipment, first aid kits, evacuation routes and procedures;

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- F) A hard-wired telephone, and alternative telecommunication device (i.e., TTY), as necessary, is available with the listing of telephone numbers for 911 and the nearest poison control center, the police, the fire department and emergency medical personnel; and
  - G) There is a plan for alternative living arrangements should a site become uninhabitable.
- 5) The provider shall implement procedures for evacuation which ensures that:
- A) Evacuation drills are conducted at a frequency determined by the provider to be appropriate based on the needs and abilities of the consumers living at the site but no less than three times per year in Transitional Level of Care no less than annually on each shift in Supervised Transitional Level of Care sites.
  - B) Special provision shall be made for those consumers who cannot evacuate the building without assistance, including those with physical limitations, and those who are deaf or blind.
  - C) All employees are trained to carry out their assigned evacuation tasks.

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- D) Inefficiency or problems identified during an evacuation drill shall result in specific corrective action.
- E) Evacuation drills shall include actual evacuation of consumers to safe areas.
- 6) At least one approved fire extinguisher shall be available in each site, inspected annually and recharged when necessary. If the site has multiple floors, one fire extinguisher shall be available on each floor.
- 7) At least one first aid kit shall be available and inspected and re-supplied regularly by the provider.

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- 8) Prior to the first consumer moving into a new site, the site must be approved by DMH, have a fire clearance on file with BALC and be certified by BALC. All new sites will be reviewed by BALC at least once during the three-year period of certification to determine compliance with this Part.
- f) The provider shall be responsible for ensuring that:
  - 1) Each site is in good repair and free from the following: cracks in floor, walls, or ceiling; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering; loose handrails or railings; loose or broken window panes; and other similar hazards.
  - 2) All electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems are in safe, clean and functional condition. This shall include regular documented inspections of the systems.
  - 3) All electrical cords and appliances are in a safe and functioning condition.
  - 4) The interior and exterior finishes of the building are clean and safe.
  - 5) All furniture and furnishings made available by the provider are clean, safe and in good repair.

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- 6) The grounds are in a safe and sanitary condition.
- 7) Floors are clean, as non-slip as possible, and free from tripping hazards.
- 8) Odors are controlled by cleaning and proper use of ventilation systems. Deodorants shall not be used to cover up persistent odors caused by unsanitary conditions or poor housekeeping practices.
- 9) Attics, basements, stairways, and similar areas are free of accumulation of refuse, discarded furniture, old newspaper, boxes, discarded equipment, and other items.

Ld seem to me

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- 10) Site bathtubs, shower stalls, and lavatories are not ~~be~~ used for laundering, janitorial, or storage purposes.
  - 11) Sites shall have adequate containers with proper covers to be used for daily storage of rubbish, and poisonous cleaning supplies.  
(COMMENT: SHOULD POISONOUS CLEANING SUPPLIES BE STORED IN A LOCKED LOCATION?)
- g) A site may be immediately closed when:
- 1) The number of staff available is less than required by this Part and additional staff cannot be brought in; (COMMENT: WHAT SPECIFICALLY IS THE REQUIRED LEVEL OF STAFF? THE ONLY REFERENCE TO STAFFING LEVELS PREVIOUS TO THIS PARAGRAPH IS IN SECTION 140.100.2. IN THAT PARAGRAPH, THE REQUIREMENT IS FOR "SUFFICIENT" STAFFING. WHAT LEVEL OF STAFFING CONSTITUTES "SUFFICIENT" AND WHAT LEVEL OF STAFFING CONSTITUTES "LESS THAN REQUIRED"?)
  - 2) The smoke detection and fire suppression system(s) are not operable and cannot be made operable immediately; or
  - 3) The site is unsafe for habitation and cannot be made safe immediately.

Comment [MSP65]: "Adequate" would seem to be our way of saying YES

Comment [MSP66]: This is covered later in STAFFING 140.215 c1

Comment [MSP67]: This is covered later in STAFFING 140.215 c1

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- h) The provider shall have keys for all site exterior and interior doors and the keys shall be available to staff providing a residential level of care during their work hours.

**Section 140.120 Utilization Review**

The provider shall have a written utilization review (UR) plan and ongoing assessment of the medical necessity of residential levels of care including the intensity/level of residential level of care and continued need of a residential level of care for the consumer. The written UR plan shall address:

- a) A review of the medical necessity of the current level of residential care as

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- b) determined by:
  - 1) The type, severity and chronicity of the consumer's symptoms;
  - 2) The severity of impairment in the consumer's role functioning;
  - 3) The risks that a consumer's symptoms or level of role functioning pose to the safety of the consumer or to others with whom the consumer interacts;
  - 4) The expected short-term and long-term outcome of the residential level of care needed by the consumer; and
  - 5) Progress made in response to residential care.
- b) The methods and procedures for performing and recording individual case reviews by persons not involved in providing residential care to the consumers whose records are reviewed;
- c) The authority and functions of the individual case review designated unit, which may be:
  - 1) A multi-disciplinary team representative committee, chaired by a QMHP, ~~and including QMHPs, MHPs, and RSAs; or~~ (COMMENT: ARE THESE

**Comment [MSP68]:** LIKELY TO ACCEPT if submitted during PUBLIC COMMENT period.

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PERSONNEL CONSIDERED TO BE "RESIDENTIAL STAFF"? THIS QUESTION IS IMPORTANT FOR PURPOSES OF APPLYING APPROPRIATE EXPENSES TO THE RESIDENTIAL PROGRAM ACCORDING TO REQUIREMENTS FOR CAPACITY GRANT FUNDING.)

**Comment [MSP69]:** Referencing Capacity grant funding is not indicated in this Rule.

- 2) ~~A-QMHP.~~
- d) Procedures describing the method for selecting cases for quarterly case review and the procedures for reviewing 10 percent of the consumers served under this Part annually;
- e) Procedures to ensure that the review includes and summarizes the consumer's

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- progress over the previous 90 days;
- f) Procedures to ensure that the review includes and summarizes the consumer's involvement in residential level of care planning and provision over the previous 90 days;
- g) Policies and procedures for documenting and reporting individual case review findings, determinations and recommendations to the supervising QMHP and, if applicable, the billing department;
- h) Procedures for appeal by consumers and staff affected by the UR decisions with which they disagree;
- i) Provisions for ensuring confidentiality of individual case reviews, determinations, results and/or recommendations in accordance with the Confidentiality Act, the HIPAA Act and the HITECH Act; and
- j) Procedures for following up on case review recommendations.

**Section 140.125 Accreditation**

For the purpose of certification, deemed status means that if a provider has been accredited by any of the accrediting organizations identified in Section 140.30 of this Part, DMH shall deem the provider to be in compliance with the following Sections of this Part:

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- a) 140.100(b)(2)(A) and (B);
- b) 140.100(c)(3);
- c) 140.105(a);
- d) 140.110(a)(2) and (4);
- e) 140.115(e)(4)(A-E);
- f) 140.115(e)(5)(B-E); and

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- g) 140.115(e)(6) and (7).

(COMMENT: IF A PROVIDER IS CERTIFIED, BASED ON THE PROPOSED RULE, IT IS RECOMMENDED THAT DEEMED STATUS BE PROVIDED FOR THE FOLLOWING SECTIONS OF THE RULE:

Section 140.100 (a)(1-5)

Section 140.100 (b)(B), (3)(A-C)

Section 140.100 (d)(1)(A-K)

Section 140.110 (b), (3)(4)

Section 140.115 c)(4)(A-E,G)

Section 140.115 c)(5)(a-e); (6),(7)

**SUBPART C: REQUIREMENTS FOR THE PROVISION OF RESIDENTIAL LEVELS OF CARE**

**Section 140.200 Consumer Rights and Choices**

To assure that a consumer's rights are protected and that all residential supports provided to consumers comply with the law, providers shall ensure that:

- a) A consumer's rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5].

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- b) The right of a consumer to confidentiality shall be governed by the Confidentiality Act, the HIPAA Act and the HITECH Act.
- c) The consumer has the right to make choices concerning the level of residential ~~services supports~~ received, the provider from which those ~~services supports~~ are received and the location of residence, choosing from those services available, affordable and for which the consumer is eligible. (COMMENT: DOES THE “LEVEL OF RESIDENTIAL SUPPORTS” REFER TO THE LEVEL OF RESIDENTIAL CARE – IN THIS CASE – SUPERVISED RESIDENTIAL SERVICES, OR DOES IT REFER TO CONSUMER’S RIGHT TO REFUSE SERVICE, OR DOES IT REFER TO THE CONSUMER’S RIGHT TO CHOOSE NOT TO RECEIVE A SPECIFIC SERVICE WITHIN THE RESIDENTIAL LEVEL OF CARE?)

**Comment [CAC70]:** There was significant discussion on the use of terms and the agreement was to use supports. That term is defined in the definition section.

**Comment [MSP71]:** KEEP as IS. Our language seems much clearer.

**Comment [MSP72]:** “Available” would need to mean “other than and beyond that residential provider only”; affordable is too exclusionary.

**Comment [MSP73]:** YES

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- d) Justification for restriction of a consumer's rights under the statutes cited in subsections (a) and (b) shall be documented in the consumer's record; along with a measureable plan, signed by the consumer and supervising QMHP, on what needs to occur in order to restore the consumer's rights. This documentation may be located in the consumer's record, in the level of residential care admission policies or documents required by this part. In addition, the consumer affected by such restriction, his or her guardian and any agency designated by the consumer pursuant to (e)(2) of this subsection shall be notified of the restriction and the plan to remove the restriction.
- e) Employees shall inform the consumer prior to initiation of residential care and annually of the following while in a residential level of care:
- 1) The rights in accordance with subsection (a), (b) and (c);
  - 2) The right to contact the Guardianship and Advocacy Commission and Equip for Equality, Inc. Employees shall offer assistance to a consumer in contacting these groups, giving each consumer the address and telephone number of the Guardianship and Advocacy Commission and Equip for Equality, Inc.;
  - 3) The right to be free from abuse, neglect, and exploitation;

**Comment [MSP74]:** Not in “admission policies” since the action needed for rights to be restored is consumer specific not universal. KEEP ONLY in medical record.

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- 4) The right to petition DMH to be provided a residential levels of care in the least restrictive setting;
- 5) The right or the guardian's right to present grievances up to and including the provider's executive director or comparable position. The consumer or guardian will be informed on how his/her grievances will be handled at the provider level. A record of such grievances and the response to those grievances shall be maintained by the provider. The executive director's decision on the grievance shall constitute a final administrative decision (except when such decisions are reviewable by the provider's governing board, in which case the governing board's decision is the final authority at the provider level);
- 6) The right under the Americans With Disabilities Act, as amended, that no

**Comment [MSP75]:** NO DMH is not providing the LOC.

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otherwise qualified disabled individual shall, solely by reason of such disability, be excluded from participation in, be denied the benefits of or be subjected to discrimination in programs, services or activities sponsored by the provider, to include reasonable modification to policies. The right to reasonable modification, auxiliary aids and services upon request by or on behalf of an individual with a disability; (COMMENT: CAN A RESIDENT BE DISCHARGED FOR NON-COMPLIANCE WITH PROGRAM? THE RESIDENT HAS THE RIGHT TO REFUSE SERVICES. THERE IS REFERENCE IN THE PROPOSED RULE THAT AN ANNUAL CASE REVIEW AND AUTHORIZATION/RE-AUTHORIZATION PROCESS IS REQUIRED, INCLUDING AN EVALUATION OF "PROGRESS MADE IN RESONSE TO TREATMENT". UNDER WHAT CIRCUMSTANCES MAY A RESIDENT BE DISCHARGED FROM A PROGRAM? IS DISCHARGE INTO HOMELESSNESS PROHIBITED.)

**Comment [MSP76]:** YES. Section 140.205(b) talks about discharge, as does section 140.215(e).

**Comment [CAC77]:** Section 140.205(b) talks about discharge, as does section 140.215(e). This is not housing, but a transitional residential level of care with an expectation that consumers will be helped to move into housing. We want to encourage providers to do that and not to treat this as permanent housing.

- 7) The right not to be denied, suspended or terminated from a residential level of care for exercising any rights; and
- 8) The right to contact DMH or its designee and to be informed of DMH's process for reviewing grievances.

**Comment [MSP78]:** NOT appropriate for RULE language.

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- f) The information in subsection (e) above shall be explained using language or a method of communication that the consumer understands and documentation of such explanation shall be placed in the consumer's record.

**Section 140.205 General Provisions**

A provider shall comply with the following:

- a) Informed Consent
  - 1) Prior to the initiation of a residential level of care, the provider shall obtain written or oral consent that confirms that both expected benefits as well as any potential consequences of any proposed residential level of care have been explained to the consumer and the consumer's guardian, as

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applicable.

- 2) Alternative formats of all forms and documents, and qualified sign language interpreters are to be available and provided upon request, and/or as indicated.
  - 3) Legally competent adults who participate in residential levels of care are deemed to have consented.
  - 4) Oral consent shall also be documented in the record.
- b) When discharging a consumer from a residential level of care, the provider shall:
    - 1) Communicate relevant treatment and service information prior to or at the time that the consumer is transferred to a receiving program of the provider or is terminated from a residential level of care and referred to a program operated by another provider, if the consumer or guardian, as appropriate, provides written authorization; and
    - 2) Document in the consumer's record the referrals to other human service providers and follow-up efforts to link the consumers to services.

**Section 140.210 Residential Level of Care Covered by This Part**

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DMH funded Supervised Transitional Level of Care will be provided in DHS certified sites. It will be provided 24 hours per day, seven days per week. The standards in this Part do not apply to Individual Care Grants (ICG).

**Section 140.215 Supervised Transitional Residential Level of Care**

- a) This level provides around the clock residential care to consumers within a residential site that assists them to continue with their recovery and increase self-sufficiency and independence.
- b) A consumer's Supervised Transitional Residential Level of Care will be reimbursed by DMH when:

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- 1) The consumer's symptoms/behaviors indicate a need for continuous monitoring and supervision;
- 2) The consumer has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills or community/family integration;
- 3) The consumer has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the consumer's needs;
- 4) The consumer has a history of unstable housing due to a behavioral health issue or a history of unstable housing that exacerbates a behavioral health condition; and
- 5) The consumer is an adult and has an assessment that indicates a need for a level of care requiring high intensity community-based residential care, medically monitored non-residential services, or medically monitored residential care, ~~obtained within the 30 days prior to placement.~~

Comment [MSP79]: Keep AS IS.

- c) Staff in Supervised Transitional Residential Level of Care Facilities

- 1) At a minimum, there shall be one RSA on duty, awake and accessible to

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consumers living at a site, including evenings and weekends whenever even one consumer is present in the residence. (COMMENT: ARE THERE ANY OTHER STAFFING REQUIREMENTS FOR ON-SITE SUPERVISION? THIS QUESTION RELATES TO PREVIOUS SECTIONS OF THE PROPOSED RULE – SECTION 140.100.C, IN WHICH “SUFFICIENT STAFFING” IS REQUIRED AND IN SECTION 140.115.G, IN WHICH “LESS THAN REQUIRED” STAFFING IS CITED AS PROBLEMATIC.)

**Comment [MSP80]:** No except as “adequately” as referenced in 140.100 a2 .

**Comment [MSP81]:** This relates to DMH’S requirement minimum.

2) There shall be access to nursing services when needed by consumers. (COMMENT: PLEASE FURTHER DEFINE ACCESS. DOES ACCESS INCLUDE THE REQUIREMENT TO HAVE NURSING STAFF ON-CALL AND/OR AVAILABLE FOR NURSING NEEDS THAT MAY TYPICALLY BE PROVIDED IN A PRIMARY CARE SETTING? DOES THIS ACCESS

**Comment [MSP82]:** ACCESS means to “obtain or make use of”.

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INCLUDE WOUND CARE, INJECTIONS, OTHER NURSING SERVICES?)

3) Clinical supervision shall be provided by a QMHP. (COMMENT: IS THE QMHP CONSIDERED TO BE A PART OF THE RESIDENTIAL STAFFING PATTERN? THIS IS IMPORTANT FOR REPORTING OF EXPENSES ASSOCIATED WITH THE LEVEL OF RESIDENTIAL SERVICE.)

**Comment [CAC83]:** The rate methodology has an allowance for Q supervision.

**Comment [MSP84]:** What constitutes Allowable Expenses are defined elsewhere for CFR /reconciliation process. but this is not projected to be a grant program.

WILL ADMISSION REQUIREMENTS LIMIT PARTICIPATION TO ONLY MEDICAID-ELIGIBLE INDIVIDUALS? THE FY 2014 CONTRACT SPECIFIES ADMISSION AS BEING RESTRICTED TO “CATEGORY 1” [MEDICAID ELIGIBLE] INDIVIDUALS. CURRENTLY THERE MAY BE SOME INDIVIDUALS THAT DO NOT MEET THAT CRITERIA. HOW SHALL PROVIDERS PROCEED?

**Comment [MSP85]:** Yes to Medicaid only. Attempt to secure Medicaid eligibility for those person.

WE PROPOSED THAT THE SUPERVISED TRANSITIONAL RESIDENTIAL LEVEL OF CARE SETTING INCLUDE:

1. THE GROUP HOME MODEL, WITH STAFF ON-SITE AROUND THE CLOCK AND INCLUDING A CONGREGATE LIVING ARRANGEMENT IN WHICH CONSUMERS HAVE THEIR OWN OR SHARE- A BEDROOM, SHARE A BATHROOM AND SHARE

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COMMON LIVING ROOM DINING ROOM AND KITCHEN FACILITIES. -

2. MH CILA MODEL

THE STAFFING REQUIREMENTS FOR A SUPERVISED RESIDENTIAL SETTING ARE NOT CLEARLY DEFINED IN THE PROPOSED RULE AND DON'T SEEM TO REFLECT THE VARIETY OF SETTINGS THAT ARE CURRENTLY OPERATED. IF THE DIVISION WISHES TO MAINTAIN CURRENT RESIDENTIAL SERVICE CAPACITY, SOME FLEXIBILITY IN DESIGNATING A "SITE" AS "SUPERVISED RESIDENTIAL LEVEL OF CARE" MAY BE NECESSARY. FOR EXAMPLE, A GROUP HOME FOR FOUR PEOPLE, OR AN APARTMENT BUILDING WITH FOUR UNITS WOULD HAVE THE SAME MINIMUM STAFFING REQUIREMENT AS A SITE

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SERVING SIXTEEN INDIVIDUALS IN A TRADITIONAL GROUP HOME SETTING.

IT IS RECOMMENDED THAT RESIDENTIAL SITES CONSISTING OF INDIVIDUAL UNITS, WHERE THE CONSUMER HAS RIGHTS OF TENANCY [HOLDS THE LEASE TO THE UNIT] BE CONSIDERED AS "SUPPORTED" RATHER THAN "SUPERVISED" RESIDENTIAL SERVICES.

FOR PROVIDERS OPERATING A RESIDENTIAL SERVICE AND WHOSE SITE DOES NOT FIT INTO THE NEWLY PROPOSED SUPERVISED RESIDENTIAL SERVICE RULE PARAMETERS, A CONCERN EXISTS THAT THEIR SITE MAY BE AT RISK FOR CONTINUED OPERATION. IT IS RECOMMENDED THAT PROVIDERS OF EXISTING RESIDENTIAL SERVICES BE PROVIDED WITH RE-ASSURANCE THAT THE DIVISION WISHES TO RETAIN ALL EXISTING QUALITY RESIDENTIAL SERVICE SITES AS THE DIVISION TRANSITIONS RESIDENTIAL SERVICES TO A REGULATED ENVIRONMENT. AS THE DIVISION PURSUES THE REGULATION OF RESIDENTIAL SERVICES, SOME SITES MAY COME TO BE CLASSIFIED AS "SUPERVISED", OTHERS MAY LATER BE CLASSIFIED AS "SUPPORTED" AND OTHERS AS "PERMANENT SUPPORTIVE

**Comment [MSP86]:** The definition of 'site' does need to be modified.

DMH wishes to be clear that it expects, that because of acuity of consumer need for entry into Supervised Residential, that the "site" should reflect characteristics to adequately respond to the needs of the consumer.

The site should afford all participating consumers individual living quarters as defined in Rule with communal facilities for food, recreation and care all within the same distinct section or unit in which all admitted consumers at the same time can receive supervision through the physical presence of, at the minimum one, staff member.

Current sites not meeting the new Rule's requirement will likely convert to other levels of care/housing designation

**Comment [MSP87]:** Supervised Transitional is the proposed LOC. CILAs or groups home wishing to convert will need to meet the new Supervised Transitional standards as in this Rule.

**Comment [MSP88]:** SEE 140.215 c1

**Comment [MSP89]:** They can staff above our minimum and should according to their assessed need for "adequacy" as in 140.100 a2.

**Comment [MSP90]:** Current sites not meeting the new Rule's requirement will likely convert to other levels of care/housing designation

**Comment [MSP91]:** Current sites not meeting the new Rule's requirement will likely convert to other levels of care/housing designation.

**Comment [MSP92]:** Current sites not meeting the new Rule's requirement will likely convert to other levels of care/housing designation.

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HOUSING” SITES. BECAUSE THESE CLASSIFICATIONS HAVE NOT BEEN DEVELOPED, A REASSURANCE FROM THE DIVISION TO CURRENT PROVIDERS THAT THEIR SITES WILL CONTINUE TO BE VALUED BY THE DIVISION AND AN INDICATION OF FLEXIBILITY FROM THE DEPARTMENT WOULD BE VERY HELPFUL AS THE RESIDENTIAL SERVICES “SYSTEM” ACCOMODATES REGULATION).

- e) Consumers requiring this level of residential care, in order to facilitate their recovery and independence, shall be expected to participate in medically necessary services as defined in 59 Ill. Adm. Code 132 and specified in the consumer’s individual treatment plan as required by 59 Ill. Adm. Code 132. (COMMENT: DOES THIS PARAGRAPH SUGGEST THAT THE CONSUMER MUST PARTICIPATE IN SERVICES OR RISK DISCHARGE? WHAT POLICY SHALL PROVIDERS FOLLOW

**Comment [MSP93]:** We assert our interest in maintaining the aggregate number of residential /housing stock but not necessarily all those #S as under current classifications

**Comment [MSP94]:** Non-compliance to treatment services could suggest a need for an alternative placement. What we are trying to say here in that the acuity of needs and services delivery should both be fairly “acute”.

Section 140.205(b) talks about discharge, as does section 140.215(e)

NOTICE OF PROPOSED RULE

CONCERNING DISCHARGE OR EVICTION OF A CONSUMER? SOME BUILDINGS ARE SUBJECT TO FINANCING REQUIREMENTS PROHIBITING EVICTION. HOW DOES THIS PARAGRAPH RELATE TO THOSE RIGHTS OUTLINED IN THE PROPOSED RIGHTS OF CONSUMERS SECTION ABOVE? )

- e) A plan for discharge shall be developed within 30 days of entry into this level of care, shall be reviewed at least every 6 months until discharge occurs and shall include:
- 1) Estimated length of time this level of care will be required;
  - 2) Skills to be developed while in this level of care; and
  - 3) Continuity of care planning.

**Comment [MSP95]:** Advise us of these specific prohibitions – this isn’t permanent housing or an treatment entitlement. Persons not progressing or benefiting should be provided alternatives.

Section 140.205(b) talks about discharge, as does section 140.215(e)