

1 AN ACT concerning public aid.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Illinois Act on the Aging is amended by
5 changing Section 4.02 as follows:

6 (20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

7 Sec. 4.02. Community Care Program. The Department shall
8 establish a program of services to prevent unnecessary
9 institutionalization of persons age 60 and older in need of
10 long term care or who are established as persons who suffer
11 from Alzheimer's disease or a related disorder under the
12 Alzheimer's Disease Assistance Act, thereby enabling them to
13 remain in their own homes or in other living arrangements. Such
14 preventive services, which may be coordinated with other
15 programs for the aged and monitored by area agencies on aging
16 in cooperation with the Department, may include, but are not
17 limited to, any or all of the following:

18 (a) (blank);

19 (b) (blank);

20 (c) home care aide services;

21 (d) personal assistant services;

22 (e) adult day services;

23 (f) home-delivered meals;

- 1 (g) education in self-care;
- 2 (h) personal care services;
- 3 (i) adult day health services;
- 4 (j) habilitation services;
- 5 (k) respite care;
- 6 (k-5) community reintegration services;
- 7 (k-6) flexible senior services;
- 8 (k-7) medication management;
- 9 (k-8) emergency home response;
- 10 (l) other nonmedical social services that may enable
- 11 the person to become self-supporting; or
- 12 (m) clearinghouse for information provided by senior
- 13 citizen home owners who want to rent rooms to or share
- 14 living space with other senior citizens.

15 Individuals who meet the following criteria shall have

16 equal access to services under the Community Care Program: ~~The~~

17 ~~Department shall establish eligibility standards for such~~

18 ~~services.~~

19 (a) are 60 years old or older;

20 (b) are U.S. citizens or legal aliens;

21 (c) are residents of Illinois;

22 (d) have non-exempt assets of \$17,500 or less;

23 non-exempt assets do not include home, car, or personal

24 furnishings; and

25 (e) have an assessed need for long term care, as

26 provided in this Section, and are at risk for nursing

1 facility placement as measured by the determination of need
2 assessment tool or a future updated assessment tool.

3 In determining the amount and nature of services for which a
4 person may qualify, consideration shall not be given to the
5 value of cash, property or other assets held in the name of the
6 person's spouse pursuant to a written agreement dividing
7 marital property into equal but separate shares or pursuant to
8 a transfer of the person's interest in a home to his spouse,
9 provided that the spouse's share of the marital property is not
10 made available to the person seeking such services.

11 Need for long term care shall be determined as follows:

12 Individuals with a score of 29 or higher based on the
13 determination of need (DON) assessment tool shall be eligible
14 to receive institutional and home and community-based long term
15 care services until the State receives federal approval and
16 implements an updated assessment tool, and those individuals
17 are found to be ineligible under that updated assessment tool.

18 Anyone determined to be ineligible for services due to the
19 updated assessment tool shall continue to be eligible for
20 services for at least one year following that determination and
21 must be reassessed no earlier than 11 months after that
22 determination. The Department must adopt rules through the
23 regular rulemaking process regarding the updated assessment
24 tool, and shall not adopt emergency or peremptory rules
25 regarding the updated assessment tool. The State shall not
26 implement an updated assessment tool that causes more than 1%

1 of then-current recipients to lose eligibility.

2 Service cost maximums shall be set at levels no lower than
3 the service cost maximums that were in effect as of January 1,
4 2016. Service cost maximums shall be increased accordingly to
5 reflect any rate increases.

6 Beginning January 1, 2008, the Department shall require as
7 a condition of eligibility that all new financially eligible
8 applicants apply for and enroll in medical assistance under
9 Article V of the Illinois Public Aid Code in accordance with
10 rules promulgated by the Department.

11 The Department shall not: (i) adopt any rule that restricts
12 eligibility under the Community Care Program to persons who
13 qualify for medical assistance under Article V of the Illinois
14 Public Aid Code; or (ii) establish, by rule, a separate program
15 of home and community-based long term care services for persons
16 who are otherwise eligible for services under the Community
17 Care Program but who do not qualify for medical assistance
18 under Article V of the Illinois Public Aid Code.

19 The Department shall, in conjunction with the Department of
20 Public Aid (now Department of Healthcare and Family Services),
21 seek appropriate amendments under Sections 1915 and 1924 of the
22 Social Security Act. The purpose of the amendments shall be to
23 extend eligibility for home and community based services under
24 Sections 1915 and 1924 of the Social Security Act to persons
25 who transfer to or for the benefit of a spouse those amounts of
26 income and resources allowed under Section 1924 of the Social

1 Security Act. Subject to the approval of such amendments, the
2 Department shall extend the provisions of Section 5-4 of the
3 Illinois Public Aid Code to persons who, but for the provision
4 of home or community-based services, would require the level of
5 care provided in an institution, as is provided for in federal
6 law. Those persons no longer found to be eligible for receiving
7 noninstitutional services due to changes in the eligibility
8 criteria shall be given 45 days notice prior to actual
9 termination. Those persons receiving notice of termination may
10 contact the Department and request the determination be
11 appealed at any time during the 45 day notice period. The
12 target population identified for the purposes of this Section
13 are persons age 60 and older with an identified service need.
14 Priority shall be given to those who are at imminent risk of
15 institutionalization. The services shall be provided to
16 eligible persons age 60 and older to the extent that the cost
17 of the services together with the other personal maintenance
18 expenses of the persons are reasonably related to the standards
19 established for care in a group facility appropriate to the
20 person's condition. These non-institutional services, pilot
21 projects or experimental facilities may be provided as part of
22 or in addition to those authorized by federal law or those
23 funded and administered by the Department of Human Services.
24 The Departments of Human Services, Healthcare and Family
25 Services, Public Health, Veterans' Affairs, and Commerce and
26 Economic Opportunity and other appropriate agencies of State,

1 federal and local governments shall cooperate with the
2 Department on Aging in the establishment and development of the
3 non-institutional services. The Department shall require an
4 annual audit from all personal assistant and home care aide
5 vendors contracting with the Department under this Section. The
6 annual audit shall assure that each audited vendor's procedures
7 are in compliance with Department's financial reporting
8 guidelines requiring an administrative and employee wage and
9 benefits cost split as defined in administrative rules. The
10 audit is a public record under the Freedom of Information Act.
11 The Department shall execute, relative to the nursing home
12 prescreening project, written inter-agency agreements with the
13 Department of Human Services and the Department of Healthcare
14 and Family Services, to effect the following: (1) intake
15 procedures and common eligibility criteria for those persons
16 who are receiving non-institutional services; and (2) the
17 establishment and development of non-institutional services in
18 areas of the State where they are not currently available or
19 are undeveloped. On and after July 1, 1996, all nursing home
20 prescreenings for individuals 60 years of age or older shall be
21 conducted by the Department.

22 As part of the Department on Aging's routine training of
23 case managers and case manager supervisors, the Department may
24 include information on family futures planning for persons who
25 are age 60 or older and who are caregivers of their adult
26 children with developmental disabilities. The content of the

1 training shall be at the Department's discretion.

2 The Department is authorized to establish a system of
3 recipient copayment for services provided under this Section,
4 such copayment to be based upon the recipient's ability to pay
5 but in no case to exceed the actual cost of the services
6 provided. Additionally, any portion of a person's income which
7 is equal to or less than the federal poverty standard shall not
8 be considered by the Department in determining the copayment.
9 The level of such copayment shall be adjusted whenever
10 necessary to reflect any change in the officially designated
11 federal poverty standard. The Department shall not increase
12 copayment levels to the levels that were in effect on January
13 1, 2016, except to make an adjustment for inflation.

14 The Department, or the Department's authorized
15 representative, may recover the amount of moneys expended for
16 services provided to or in behalf of a person under this
17 Section by a claim against the person's estate or against the
18 estate of the person's surviving spouse, but no recovery may be
19 had until after the death of the surviving spouse, if any, and
20 then only at such time when there is no surviving child who is
21 under age 21 or blind or who has a permanent and total
22 disability. This paragraph, however, shall not bar recovery, at
23 the death of the person, of moneys for services provided to the
24 person or in behalf of the person under this Section to which
25 the person was not entitled; provided that such recovery shall
26 not be enforced against any real estate while it is occupied as

1 a homestead by the surviving spouse or other dependent, if no
2 claims by other creditors have been filed against the estate,
3 or, if such claims have been filed, they remain dormant for
4 failure of prosecution or failure of the claimant to compel
5 administration of the estate for the purpose of payment. This
6 paragraph shall not bar recovery from the estate of a spouse,
7 under Sections 1915 and 1924 of the Social Security Act and
8 Section 5-4 of the Illinois Public Aid Code, who precedes a
9 person receiving services under this Section in death. All
10 moneys for services paid to or in behalf of the person under
11 this Section shall be claimed for recovery from the deceased
12 spouse's estate. "Homestead", as used in this paragraph, means
13 the dwelling house and contiguous real estate occupied by a
14 surviving spouse or relative, as defined by the rules and
15 regulations of the Department of Healthcare and Family
16 Services, regardless of the value of the property.

17 The Department shall increase the effectiveness of the
18 existing Community Care Program by:

19 (1) ensuring that in-home services included in the care
20 plan are available on evenings and weekends;

21 (2) ensuring that care plans contain the services that
22 eligible participants need based on the number of days in a
23 month, not limited to specific blocks of time, as
24 identified by the comprehensive assessment tool selected
25 by the Department for use statewide, not to exceed the
26 total monthly service cost maximum allowed for each

1 service; the Department shall develop administrative rules
2 to implement this item (2);

3 (3) ensuring that the participants have the right to
4 choose the services contained in their care plan and to
5 direct how those services are provided, based on
6 administrative rules established by the Department;

7 (4) ensuring that the determination of need tool is
8 accurate in determining the participants' level of need; to
9 achieve this, the Department, in conjunction with the Older
10 Adult Services Advisory Committee, shall institute a study
11 of the relationship between the Determination of Need
12 scores, level of need, service cost maximums, and the
13 development and utilization of service plans no later than
14 May 1, 2008; findings and recommendations shall be
15 presented to the Governor and the General Assembly no later
16 than January 1, 2009; recommendations shall include all
17 needed changes to the service cost maximums schedule and
18 additional covered services;

19 (5) ensuring that homemakers can provide personal care
20 services that may or may not involve contact with clients,
21 including but not limited to:

22 (A) bathing;

23 (B) grooming;

24 (C) toileting;

25 (D) nail care;

26 (E) transferring;

1 (F) respiratory services;

2 (G) exercise; or

3 (H) positioning;

4 (6) ensuring that homemaker program vendors are not
5 restricted from hiring homemakers who are family members of
6 clients or recommended by clients; the Department may not,
7 by rule or policy, require homemakers who are family
8 members of clients or recommended by clients to accept
9 assignments in homes other than the client;

10 (7) ensuring that the State may access maximum federal
11 matching funds by seeking approval for the Centers for
12 Medicare and Medicaid Services for modifications to the
13 State's home and community based services waiver and
14 additional waiver opportunities, including applying for
15 enrollment in the Balance Incentive Payment Program by May
16 1, 2013, in order to maximize federal matching funds; this
17 shall include, but not be limited to, modification that
18 reflects all changes in the Community Care Program services
19 and all increases in the services cost maximum;

20 (8) ensuring that the determination of need tool
21 accurately reflects the service needs of individuals with
22 Alzheimer's disease and related dementia disorders;

23 (9) ensuring that services are authorized accurately
24 and consistently for the Community Care Program (CCP); the
25 Department shall implement a Service Authorization policy
26 directive; the purpose shall be to ensure that eligibility

1 and services are authorized accurately and consistently in
2 the CCP program; the policy directive shall clarify service
3 authorization guidelines to Care Coordination Units and
4 Community Care Program providers no later than May 1, 2013;

5 (10) working in conjunction with Care Coordination
6 Units, the Department of Healthcare and Family Services,
7 the Department of Human Services, Community Care Program
8 providers, and other stakeholders to make improvements to
9 the Medicaid claiming processes and the Medicaid
10 enrollment procedures or requirements as needed,
11 including, but not limited to, specific policy changes or
12 rules to improve the up-front enrollment of participants in
13 the Medicaid program and specific policy changes or rules
14 to insure more prompt submission of bills to the federal
15 government to secure maximum federal matching dollars as
16 promptly as possible; the Department on Aging shall have at
17 least 3 meetings with stakeholders by January 1, 2014 in
18 order to address these improvements;

19 (11) requiring home care service providers to comply
20 with the rounding of hours worked provisions under the
21 federal Fair Labor Standards Act (FLSA) and as set forth in
22 29 CFR 785.48(b) by May 1, 2013;

23 (12) implementing any necessary policy changes or
24 promulgating any rules, no later than January 1, 2014, to
25 assist the Department of Healthcare and Family Services in
26 moving as many participants as possible, consistent with

1 federal regulations, into coordinated care plans if a care
2 coordination plan that covers long term care is available
3 in the recipient's area; and

4 (13) maintaining fiscal year 2014 rates at the same
5 level established on January 1, 2013.

6 By January 1, 2009 or as soon after the end of the Cash and
7 Counseling Demonstration Project as is practicable, the
8 Department may, based on its evaluation of the demonstration
9 project, promulgate rules concerning personal assistant
10 services, to include, but need not be limited to,
11 qualifications, employment screening, rights under fair labor
12 standards, training, fiduciary agent, and supervision
13 requirements. All applicants shall be subject to the provisions
14 of the Health Care Worker Background Check Act.

15 The Department shall develop procedures to enhance
16 availability of services on evenings, weekends, and on an
17 emergency basis to meet the respite needs of caregivers.
18 Procedures shall be developed to permit the utilization of
19 services in successive blocks of 24 hours up to the monthly
20 maximum established by the Department. Workers providing these
21 services shall be appropriately trained.

22 Beginning on the effective date of this amendatory Act of
23 1991, no person may perform chore/housekeeping and home care
24 aide services under a program authorized by this Section unless
25 that person has been issued a certificate of pre-service to do
26 so by his or her employing agency. Information gathered to

1 effect such certification shall include (i) the person's name,
2 (ii) the date the person was hired by his or her current
3 employer, and (iii) the training, including dates and levels.
4 Persons engaged in the program authorized by this Section
5 before the effective date of this amendatory Act of 1991 shall
6 be issued a certificate of all pre- and in-service training
7 from his or her employer upon submitting the necessary
8 information. The employing agency shall be required to retain
9 records of all staff pre- and in-service training, and shall
10 provide such records to the Department upon request and upon
11 termination of the employer's contract with the Department. In
12 addition, the employing agency is responsible for the issuance
13 of certifications of in-service training completed to their
14 employees.

15 The Department is required to develop a system to ensure
16 that persons working as home care aides and personal assistants
17 receive increases in their wages when the federal minimum wage
18 is increased by requiring vendors to certify that they are
19 meeting the federal minimum wage statute for home care aides
20 and personal assistants. An employer that cannot ensure that
21 the minimum wage increase is being given to home care aides and
22 personal assistants shall be denied any increase in
23 reimbursement costs.

24 The Community Care Program Advisory Committee is created in
25 the Department on Aging. The Director shall appoint individuals
26 to serve in the Committee, who shall serve at their own

1 expense. Members of the Committee must abide by all applicable
2 ethics laws. The Committee shall advise the Department on
3 issues related to the Department's program of services to
4 prevent unnecessary institutionalization. The Committee shall
5 meet on a bi-monthly basis and shall serve to identify and
6 advise the Department on present and potential issues affecting
7 the service delivery network, the program's clients, and the
8 Department and to recommend solution strategies. Persons
9 appointed to the Committee shall be appointed on, but not
10 limited to, their own and their agency's experience with the
11 program, geographic representation, and willingness to serve.
12 The Director shall appoint members to the Committee to
13 represent provider, advocacy, policy research, and other
14 constituencies committed to the delivery of high quality home
15 and community-based services to older adults. Representatives
16 shall be appointed to ensure representation from community care
17 providers including, but not limited to, adult day service
18 providers, homemaker providers, case coordination and case
19 management units, emergency home response providers, statewide
20 trade or labor unions that represent home care aides and direct
21 care staff, area agencies on aging, adults over age 60,
22 membership organizations representing older adults, and other
23 organizational entities, providers of care, or individuals
24 with demonstrated interest and expertise in the field of home
25 and community care as determined by the Director.

26 Nominations may be presented from any agency or State

1 association with interest in the program. The Director, or his
2 or her designee, shall serve as the permanent co-chair of the
3 advisory committee. One other co-chair shall be nominated and
4 approved by the members of the committee on an annual basis.
5 Committee members' terms of appointment shall be for 4 years
6 with one-quarter of the appointees' terms expiring each year. A
7 member shall continue to serve until his or her replacement is
8 named. The Department shall fill vacancies that have a
9 remaining term of over one year, and this replacement shall
10 occur through the annual replacement of expiring terms. The
11 Director shall designate Department staff to provide technical
12 assistance and staff support to the committee. Department
13 representation shall not constitute membership of the
14 committee. All Committee papers, issues, recommendations,
15 reports, and meeting memoranda are advisory only. The Director,
16 or his or her designee, shall make a written report, as
17 requested by the Committee, regarding issues before the
18 Committee.

19 The Department on Aging and the Department of Human
20 Services shall cooperate in the development and submission of
21 an annual report on programs and services provided under this
22 Section. Such joint report shall be filed with the Governor and
23 the General Assembly on or before September 30 each year.

24 The requirement for reporting to the General Assembly shall
25 be satisfied by filing copies of the report with the Speaker,
26 the Minority Leader and the Clerk of the House of

1 Representatives and the President, the Minority Leader and the
2 Secretary of the Senate and the Legislative Research Unit, as
3 required by Section 3.1 of the General Assembly Organization
4 Act and filing such additional copies with the State Government
5 Report Distribution Center for the General Assembly as is
6 required under paragraph (t) of Section 7 of the State Library
7 Act.

8 Those persons previously found eligible for receiving
9 non-institutional services whose services were discontinued
10 under the Emergency Budget Act of Fiscal Year 1992, and who do
11 not meet the eligibility standards in effect on or after July
12 1, 1992, shall remain ineligible on and after July 1, 1992.
13 Those persons previously not required to cost-share and who
14 were required to cost-share effective March 1, 1992, shall
15 continue to meet cost-share requirements on and after July 1,
16 1992. Beginning July 1, 1992, all clients will be required to
17 meet eligibility, cost-share, and other requirements and will
18 have services discontinued or altered when they fail to meet
19 these requirements.

20 For the purposes of this Section, "flexible senior
21 services" refers to services that require one-time or periodic
22 expenditures including, but not limited to, respite care, home
23 modification, assistive technology, housing assistance, and
24 transportation.

25 The Department shall implement an electronic service
26 verification based on global positioning systems or other

1 cost-effective technology for the Community Care Program no
2 later than January 1, 2014.

3 ~~The Department shall require, as a condition of~~
4 ~~eligibility, enrollment in the medical assistance program~~
5 ~~under Article V of the Illinois Public Aid Code (i) beginning~~
6 ~~August 1, 2013, if the Auditor General has reported that the~~
7 ~~Department has failed to comply with the reporting requirements~~
8 ~~of Section 2-27 of the Illinois State Auditing Act; or (ii)~~
9 ~~beginning June 1, 2014, if the Auditor General has reported~~
10 ~~that the Department has not undertaken the required actions~~
11 ~~listed in the report required by subsection (a) of Section 2-27~~
12 ~~of the Illinois State Auditing Act.~~

13 ~~The Department shall delay Community Care Program services~~
14 ~~until an applicant is determined eligible for medical~~
15 ~~assistance under Article V of the Illinois Public Aid Code (i)~~
16 ~~beginning August 1, 2013, if the Auditor General has reported~~
17 ~~that the Department has failed to comply with the reporting~~
18 ~~requirements of Section 2-27 of the Illinois State Auditing~~
19 ~~Act; or (ii) beginning June 1, 2014, if the Auditor General has~~
20 ~~reported that the Department has not undertaken the required~~
21 ~~actions listed in the report required by subsection (a) of~~
22 ~~Section 2-27 of the Illinois State Auditing Act.~~

23 ~~The Department shall implement co-payments for the~~
24 ~~Community Care Program at the federally allowable maximum level~~
25 ~~(i) beginning August 1, 2013, if the Auditor General has~~
26 ~~reported that the Department has failed to comply with the~~

1 ~~reporting requirements of Section 2-27 of the Illinois State~~
2 ~~Auditing Act; or (ii) beginning June 1, 2014, if the Auditor~~
3 ~~General has reported that the Department has not undertaken the~~
4 ~~required actions listed in the report required by subsection~~
5 ~~(a) of Section 2-27 of the Illinois State Auditing Act.~~

6 The Department shall provide a bi-monthly report on the
7 progress of the Community Care Program reforms set forth in
8 this amendatory Act of the 98th General Assembly to the
9 Governor, the Speaker of the House of Representatives, the
10 Minority Leader of the House of Representatives, the President
11 of the Senate, and the Minority Leader of the Senate.

12 The Department shall conduct a quarterly review of Care
13 Coordination Unit performance and adherence to service
14 guidelines. The quarterly review shall be reported to the
15 Speaker of the House of Representatives, the Minority Leader of
16 the House of Representatives, the President of the Senate, and
17 the Minority Leader of the Senate. The Department shall collect
18 and report longitudinal data on the performance of each care
19 coordination unit. Nothing in this paragraph shall be construed
20 to require the Department to identify specific care
21 coordination units.

22 In regard to community care providers, failure to comply
23 with Department on Aging policies shall be cause for
24 disciplinary action, including, but not limited to,
25 disqualification from serving Community Care Program clients.
26 Each provider, upon submission of any bill or invoice to the

1 Department for payment for services rendered, shall include a
2 notarized statement, under penalty of perjury pursuant to
3 Section 1-109 of the Code of Civil Procedure, that the provider
4 has complied with all Department policies.

5 The Director of the Department on Aging shall make
6 information available to the State Board of Elections as may be
7 required by an agreement the State Board of Elections has
8 entered into with a multi-state voter registration list
9 maintenance system.

10 (Source: P.A. 98-8, eff. 5-3-13; 98-1171, eff. 6-1-15; 99-143,
11 eff. 7-27-15.)

12 Section 10. The Rehabilitation of Persons with
13 Disabilities Act is amended by changing Section 3 as follows:

14 (20 ILCS 2405/3) (from Ch. 23, par. 3434)

15 Sec. 3. Powers and duties. The Department shall have the
16 powers and duties enumerated herein:

17 (a) To co-operate with the federal government in the
18 administration of the provisions of the federal Rehabilitation
19 Act of 1973, as amended, of the Workforce Investment Act of
20 1998, and of the federal Social Security Act to the extent and
21 in the manner provided in these Acts.

22 (b) To prescribe and supervise such courses of vocational
23 training and provide such other services as may be necessary
24 for the habilitation and rehabilitation of persons with one or

1 more disabilities, including the administrative activities
2 under subsection (e) of this Section, and to co-operate with
3 State and local school authorities and other recognized
4 agencies engaged in habilitation, rehabilitation and
5 comprehensive rehabilitation services; and to cooperate with
6 the Department of Children and Family Services regarding the
7 care and education of children with one or more disabilities.

8 (c) (Blank).

9 (d) To report in writing, to the Governor, annually on or
10 before the first day of December, and at such other times and
11 in such manner and upon such subjects as the Governor may
12 require. The annual report shall contain (1) a statement of the
13 existing condition of comprehensive rehabilitation services,
14 habilitation and rehabilitation in the State; (2) a statement
15 of suggestions and recommendations with reference to the
16 development of comprehensive rehabilitation services,
17 habilitation and rehabilitation in the State; and (3) an
18 itemized statement of the amounts of money received from
19 federal, State and other sources, and of the objects and
20 purposes to which the respective items of these several amounts
21 have been devoted.

22 (e) (Blank).

23 (f) To establish a program of services to prevent the
24 unnecessary institutionalization of persons in need of long
25 term care and who meet the criteria for blindness or disability
26 as defined by the Social Security Act, thereby enabling them to

1 remain in their own homes. Such preventive services include any
2 or all of the following:

- 3 (1) personal assistant services;
- 4 (2) homemaker services;
- 5 (3) home-delivered meals;
- 6 (4) adult day care services;
- 7 (5) respite care;
- 8 (6) home modification or assistive equipment;
- 9 (7) home health services;
- 10 (8) electronic home response;
- 11 (9) brain injury behavioral/cognitive services;
- 12 (10) brain injury habilitation;
- 13 (11) brain injury pre-vocational services; or
- 14 (12) brain injury supported employment.

15 The Department shall establish eligibility standards for
16 such services taking into consideration the unique economic and
17 social needs of the population for whom they are to be
18 provided. Such eligibility standards may be based on the
19 recipient's ability to pay for services; provided, however,
20 that any portion of a person's income that is equal to or less
21 than the "protected income" level shall not be considered by
22 the Department in determining eligibility. The "protected
23 income" level shall be determined by the Department, shall
24 never be less than the federal poverty standard, and shall be
25 adjusted each year to reflect changes in the Consumer Price
26 Index For All Urban Consumers as determined by the United

1 States Department of Labor. The standards must provide that a
2 person may not have more than \$10,000 in assets to be eligible
3 for the services, and the Department may increase or decrease
4 the asset limitation by rule. The Department may not decrease
5 the asset level below \$10,000.

6 Individuals with a score of 29 or higher based on the
7 determination of need (DON) assessment tool shall be eligible
8 to receive institutional and home and community-based long term
9 care services until the State receives federal approval and
10 implements an updated assessment tool, and those individuals
11 are found to be ineligible under that updated assessment tool.
12 Anyone determined to be ineligible for services due to the
13 updated assessment tool shall continue to be eligible for
14 services for at least one year following that determination and
15 must be reassessed no earlier than 11 months after that
16 determination. The Department must adopt rules through the
17 regular rulemaking process regarding the updated assessment
18 tool, and shall not adopt emergency or peremptory rules
19 regarding the updated assessment tool. The State shall not
20 implement an updated assessment tool that causes more than 1%
21 of then-current recipients to lose eligibility.

22 Service cost maximums shall be set at levels no lower than
23 the service cost maximums that were in effect as of January 1,
24 2016. Service cost maximums shall be increased accordingly to
25 reflect any rate increases.

26 The services shall be provided, as established by the

1 Department by rule, to eligible persons to prevent unnecessary
2 or premature institutionalization, to the extent that the cost
3 of the services, together with the other personal maintenance
4 expenses of the persons, are reasonably related to the
5 standards established for care in a group facility appropriate
6 to their condition. These non-institutional services, pilot
7 projects or experimental facilities may be provided as part of
8 or in addition to those authorized by federal law or those
9 funded and administered by the Illinois Department on Aging.
10 The Department shall set rates and fees for services in a fair
11 and equitable manner. Services identical to those offered by
12 the Department on Aging shall be paid at the same rate.

13 Personal assistants shall be paid at a rate negotiated
14 between the State and an exclusive representative of personal
15 assistants under a collective bargaining agreement. In no case
16 shall the Department pay personal assistants an hourly wage
17 that is less than the federal minimum wage.

18 Solely for the purposes of coverage under the Illinois
19 Public Labor Relations Act (5 ILCS 315/), personal assistants
20 providing services under the Department's Home Services
21 Program shall be considered to be public employees and the
22 State of Illinois shall be considered to be their employer as
23 of the effective date of this amendatory Act of the 93rd
24 General Assembly, but not before. Solely for the purposes of
25 coverage under the Illinois Public Labor Relations Act, home
26 care and home health workers who function as personal

1 assistants and individual maintenance home health workers and
2 who also provide services under the Department's Home Services
3 Program shall be considered to be public employees, no matter
4 whether the State provides such services through direct
5 fee-for-service arrangements, with the assistance of a managed
6 care organization or other intermediary, or otherwise, and the
7 State of Illinois shall be considered to be the employer of
8 those persons as of January 29, 2013 (the effective date of
9 Public Act 97-1158), but not before except as otherwise
10 provided under this subsection (f). The State shall engage in
11 collective bargaining with an exclusive representative of home
12 care and home health workers who function as personal
13 assistants and individual maintenance home health workers
14 working under the Home Services Program concerning their terms
15 and conditions of employment that are within the State's
16 control. Nothing in this paragraph shall be understood to limit
17 the right of the persons receiving services defined in this
18 Section to hire and fire home care and home health workers who
19 function as personal assistants and individual maintenance
20 home health workers working under the Home Services Program or
21 to supervise them within the limitations set by the Home
22 Services Program. The State shall not be considered to be the
23 employer of home care and home health workers who function as
24 personal assistants and individual maintenance home health
25 workers working under the Home Services Program for any
26 purposes not specifically provided in Public Act 93-204 or

1 Public Act 97-1158, including but not limited to, purposes of
2 vicarious liability in tort and purposes of statutory
3 retirement or health insurance benefits. Home care and home
4 health workers who function as personal assistants and
5 individual maintenance home health workers and who also provide
6 services under the Department's Home Services Program shall not
7 be covered by the State Employees Group Insurance Act of 1971
8 (5 ILCS 375/).

9 The Department shall execute, relative to nursing home
10 prescreening, as authorized by Section 4.03 of the Illinois Act
11 on the Aging, written inter-agency agreements with the
12 Department on Aging and the Department of Healthcare and Family
13 Services, to effect the intake procedures and eligibility
14 criteria for those persons who may need long term care. On and
15 after July 1, 1996, all nursing home prescreenings for
16 individuals 18 through 59 years of age shall be conducted by
17 the Department, or a designee of the Department.

18 The Department is authorized to establish a system of
19 recipient cost-sharing for services provided under this
20 Section. The cost-sharing shall be based upon the recipient's
21 ability to pay for services, but in no case shall the
22 recipient's share exceed the actual cost of the services
23 provided. Protected income shall not be considered by the
24 Department in its determination of the recipient's ability to
25 pay a share of the cost of services. The level of cost-sharing
26 shall be adjusted each year to reflect changes in the

1 "protected income" level. The Department shall deduct from the
2 recipient's share of the cost of services any money expended by
3 the recipient for disability-related expenses.

4 To the extent permitted under the federal Social Security
5 Act, the Department, or the Department's authorized
6 representative, may recover the amount of moneys expended for
7 services provided to or in behalf of a person under this
8 Section by a claim against the person's estate or against the
9 estate of the person's surviving spouse, but no recovery may be
10 had until after the death of the surviving spouse, if any, and
11 then only at such time when there is no surviving child who is
12 under age 21 or blind or who has a permanent and total
13 disability. This paragraph, however, shall not bar recovery, at
14 the death of the person, of moneys for services provided to the
15 person or in behalf of the person under this Section to which
16 the person was not entitled; provided that such recovery shall
17 not be enforced against any real estate while it is occupied as
18 a homestead by the surviving spouse or other dependent, if no
19 claims by other creditors have been filed against the estate,
20 or, if such claims have been filed, they remain dormant for
21 failure of prosecution or failure of the claimant to compel
22 administration of the estate for the purpose of payment. This
23 paragraph shall not bar recovery from the estate of a spouse,
24 under Sections 1915 and 1924 of the Social Security Act and
25 Section 5-4 of the Illinois Public Aid Code, who precedes a
26 person receiving services under this Section in death. All

1 moneys for services paid to or in behalf of the person under
2 this Section shall be claimed for recovery from the deceased
3 spouse's estate. "Homestead", as used in this paragraph, means
4 the dwelling house and contiguous real estate occupied by a
5 surviving spouse or relative, as defined by the rules and
6 regulations of the Department of Healthcare and Family
7 Services, regardless of the value of the property.

8 The Department shall submit an annual report on programs
9 and services provided under this Section. The report shall be
10 filed with the Governor and the General Assembly on or before
11 March 30 each year.

12 The requirement for reporting to the General Assembly shall
13 be satisfied by filing copies of the report with the Speaker,
14 the Minority Leader and the Clerk of the House of
15 Representatives and the President, the Minority Leader and the
16 Secretary of the Senate and the Legislative Research Unit, as
17 required by Section 3.1 of the General Assembly Organization
18 Act, and filing additional copies with the State Government
19 Report Distribution Center for the General Assembly as required
20 under paragraph (t) of Section 7 of the State Library Act.

21 (g) To establish such subdivisions of the Department as
22 shall be desirable and assign to the various subdivisions the
23 responsibilities and duties placed upon the Department by law.

24 (h) To cooperate and enter into any necessary agreements
25 with the Department of Employment Security for the provision of
26 job placement and job referral services to clients of the

1 Department, including job service registration of such clients
2 with Illinois Employment Security offices and making job
3 listings maintained by the Department of Employment Security
4 available to such clients.

5 (i) To possess all powers reasonable and necessary for the
6 exercise and administration of the powers, duties and
7 responsibilities of the Department which are provided for by
8 law.

9 (j) (Blank).

10 (k) (Blank).

11 (l) To establish, operate and maintain a Statewide Housing
12 Clearinghouse of information on available, government
13 subsidized housing accessible to persons with disabilities and
14 available privately owned housing accessible to persons with
15 disabilities. The information shall include but not be limited
16 to the location, rental requirements, access features and
17 proximity to public transportation of available housing. The
18 Clearinghouse shall consist of at least a computerized database
19 for the storage and retrieval of information and a separate or
20 shared toll free telephone number for use by those seeking
21 information from the Clearinghouse. Department offices and
22 personnel throughout the State shall also assist in the
23 operation of the Statewide Housing Clearinghouse. Cooperation
24 with local, State and federal housing managers shall be sought
25 and extended in order to frequently and promptly update the
26 Clearinghouse's information.

1 (m) To assure that the names and case records of persons
2 who received or are receiving services from the Department,
3 including persons receiving vocational rehabilitation, home
4 services, or other services, and those attending one of the
5 Department's schools or other supervised facility shall be
6 confidential and not be open to the general public. Those case
7 records and reports or the information contained in those
8 records and reports shall be disclosed by the Director only to
9 proper law enforcement officials, individuals authorized by a
10 court, the General Assembly or any committee or commission of
11 the General Assembly, and other persons and for reasons as the
12 Director designates by rule. Disclosure by the Director may be
13 only in accordance with other applicable law.

14 (Source: P.A. 98-1004, eff. 8-18-14; 99-143, eff. 7-27-15.)

15 Section 13. The Nursing Home Care Act is amended by
16 changing Section 3-402 as follows:

17 (210 ILCS 45/3-402) (from Ch. 111 1/2, par. 4153-402)

18 Sec. 3-402. Involuntary transfer or discharge.

19 Involuntary transfer or discharge of a resident from a
20 facility shall be preceded by the discussion required under
21 Section 3-408 and by a minimum written notice of 21 days,
22 except in one of the following instances:

23 (a) When an emergency transfer or discharge is ordered
24 by the resident's attending physician because of the

1 resident's health care needs.

2 (b) When the transfer or discharge is mandated by the
3 physical safety of other residents, the facility staff, or
4 facility visitors, as documented in the clinical record.
5 The Department shall be notified prior to any such
6 involuntary transfer or discharge. The Department shall
7 immediately offer transfer, or discharge and relocation
8 assistance to residents transferred or discharged under
9 this subparagraph (b), and the Department may place
10 relocation teams as provided in Section 3-419 of this Act.

11 (c) When an identified offender is within the
12 provisional admission period defined in Section 1-120.3.
13 If the Identified Offender Report and Recommendation
14 prepared under Section 2-201.6 shows that the identified
15 offender poses a serious threat or danger to the physical
16 safety of other residents, the facility staff, or facility
17 visitors in the admitting facility and the facility
18 determines that it is unable to provide a safe environment
19 for the other residents, the facility staff, or facility
20 visitors, the facility shall transfer or discharge the
21 identified offender within 3 days after its receipt of the
22 Identified Offender Report and Recommendation.

23 No individual receiving care in an institutional setting
24 shall be involuntarily discharged as the result of the updated
25 determination of need (DON) assessment tool as provided in
26 Section 5-5 of the Illinois Public Aid Code until a transition

1 plan has been developed by the Department on Aging or its
2 designee and all care identified in the transition plan is
3 available to the resident immediately upon discharge.

4 (Source: P.A. 96-1372, eff. 7-29-10.)

5 Section 15. The Illinois Public Aid Code is amended by
6 changing Sections 5-5 and 5-5.01a as follows:

7 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

8 Sec. 5-5. Medical services. The Illinois Department, by
9 rule, shall determine the quantity and quality of and the rate
10 of reimbursement for the medical assistance for which payment
11 will be authorized, and the medical services to be provided,
12 which may include all or part of the following: (1) inpatient
13 hospital services; (2) outpatient hospital services; (3) other
14 laboratory and X-ray services; (4) skilled nursing home
15 services; (5) physicians' services whether furnished in the
16 office, the patient's home, a hospital, a skilled nursing home,
17 or elsewhere; (6) medical care, or any other type of remedial
18 care furnished by licensed practitioners; (7) home health care
19 services; (8) private duty nursing service; (9) clinic
20 services; (10) dental services, including prevention and
21 treatment of periodontal disease and dental caries disease for
22 pregnant women, provided by an individual licensed to practice
23 dentistry or dental surgery; for purposes of this item (10),
24 "dental services" means diagnostic, preventive, or corrective

1 procedures provided by or under the supervision of a dentist in
2 the practice of his or her profession; (11) physical therapy
3 and related services; (12) prescribed drugs, dentures, and
4 prosthetic devices; and eyeglasses prescribed by a physician
5 skilled in the diseases of the eye, or by an optometrist,
6 whichever the person may select; (13) other diagnostic,
7 screening, preventive, and rehabilitative services, including
8 to ensure that the individual's need for intervention or
9 treatment of mental disorders or substance use disorders or
10 co-occurring mental health and substance use disorders is
11 determined using a uniform screening, assessment, and
12 evaluation process inclusive of criteria, for children and
13 adults; for purposes of this item (13), a uniform screening,
14 assessment, and evaluation process refers to a process that
15 includes an appropriate evaluation and, as warranted, a
16 referral; "uniform" does not mean the use of a singular
17 instrument, tool, or process that all must utilize; (14)
18 transportation and such other expenses as may be necessary;
19 (15) medical treatment of sexual assault survivors, as defined
20 in Section 1a of the Sexual Assault Survivors Emergency
21 Treatment Act, for injuries sustained as a result of the sexual
22 assault, including examinations and laboratory tests to
23 discover evidence which may be used in criminal proceedings
24 arising from the sexual assault; (16) the diagnosis and
25 treatment of sickle cell anemia; and (17) any other medical
26 care, and any other type of remedial care recognized under the

1 laws of this State, but not including abortions, or induced
2 miscarriages or premature births, unless, in the opinion of a
3 physician, such procedures are necessary for the preservation
4 of the life of the woman seeking such treatment, or except an
5 induced premature birth intended to produce a live viable child
6 and such procedure is necessary for the health of the mother or
7 her unborn child. The Illinois Department, by rule, shall
8 prohibit any physician from providing medical assistance to
9 anyone eligible therefor under this Code where such physician
10 has been found guilty of performing an abortion procedure in a
11 wilful and wanton manner upon a woman who was not pregnant at
12 the time such abortion procedure was performed. The term "any
13 other type of remedial care" shall include nursing care and
14 nursing home service for persons who rely on treatment by
15 spiritual means alone through prayer for healing.

16 Notwithstanding any other provision of this Section, a
17 comprehensive tobacco use cessation program that includes
18 purchasing prescription drugs or prescription medical devices
19 approved by the Food and Drug Administration shall be covered
20 under the medical assistance program under this Article for
21 persons who are otherwise eligible for assistance under this
22 Article.

23 Notwithstanding any other provision of this Code, the
24 Illinois Department may not require, as a condition of payment
25 for any laboratory test authorized under this Article, that a
26 physician's handwritten signature appear on the laboratory

1 test order form. The Illinois Department may, however, impose
2 other appropriate requirements regarding laboratory test order
3 documentation.

4 Upon receipt of federal approval of an amendment to the
5 Illinois Title XIX State Plan for this purpose, the Department
6 shall authorize the Chicago Public Schools (CPS) to procure a
7 vendor or vendors to manufacture eyeglasses for individuals
8 enrolled in a school within the CPS system. CPS shall ensure
9 that its vendor or vendors are enrolled as providers in the
10 medical assistance program and in any capitated Medicaid
11 managed care entity (MCE) serving individuals enrolled in a
12 school within the CPS system. Under any contract procured under
13 this provision, the vendor or vendors must serve only
14 individuals enrolled in a school within the CPS system. Claims
15 for services provided by CPS's vendor or vendors to recipients
16 of benefits in the medical assistance program under this Code,
17 the Children's Health Insurance Program, or the Covering ALL
18 KIDS Health Insurance Program shall be submitted to the
19 Department or the MCE in which the individual is enrolled for
20 payment and shall be reimbursed at the Department's or the
21 MCE's established rates or rate methodologies for eyeglasses.

22 On and after July 1, 2012, the Department of Healthcare and
23 Family Services may provide the following services to persons
24 eligible for assistance under this Article who are
25 participating in education, training or employment programs
26 operated by the Department of Human Services as successor to

1 the Department of Public Aid:

2 (1) dental services provided by or under the
3 supervision of a dentist; and

4 (2) eyeglasses prescribed by a physician skilled in the
5 diseases of the eye, or by an optometrist, whichever the
6 person may select.

7 Notwithstanding any other provision of this Code and
8 subject to federal approval, the Department may adopt rules to
9 allow a dentist who is volunteering his or her service at no
10 cost to render dental services through an enrolled
11 not-for-profit health clinic without the dentist personally
12 enrolling as a participating provider in the medical assistance
13 program. A not-for-profit health clinic shall include a public
14 health clinic or Federally Qualified Health Center or other
15 enrolled provider, as determined by the Department, through
16 which dental services covered under this Section are performed.
17 The Department shall establish a process for payment of claims
18 for reimbursement for covered dental services rendered under
19 this provision.

20 The Illinois Department, by rule, may distinguish and
21 classify the medical services to be provided only in accordance
22 with the classes of persons designated in Section 5-2.

23 The Department of Healthcare and Family Services must
24 provide coverage and reimbursement for amino acid-based
25 elemental formulas, regardless of delivery method, for the
26 diagnosis and treatment of (i) eosinophilic disorders and (ii)

1 short bowel syndrome when the prescribing physician has issued
2 a written order stating that the amino acid-based elemental
3 formula is medically necessary.

4 The Illinois Department shall authorize the provision of,
5 and shall authorize payment for, screening by low-dose
6 mammography for the presence of occult breast cancer for women
7 35 years of age or older who are eligible for medical
8 assistance under this Article, as follows:

9 (A) A baseline mammogram for women 35 to 39 years of
10 age.

11 (B) An annual mammogram for women 40 years of age or
12 older.

13 (C) A mammogram at the age and intervals considered
14 medically necessary by the woman's health care provider for
15 women under 40 years of age and having a family history of
16 breast cancer, prior personal history of breast cancer,
17 positive genetic testing, or other risk factors.

18 (D) A comprehensive ultrasound screening of an entire
19 breast or breasts if a mammogram demonstrates
20 heterogeneous or dense breast tissue, when medically
21 necessary as determined by a physician licensed to practice
22 medicine in all of its branches.

23 (E) A screening MRI when medically necessary, as
24 determined by a physician licensed to practice medicine in
25 all of its branches.

26 All screenings shall include a physical breast exam,

1 instruction on self-examination and information regarding the
2 frequency of self-examination and its value as a preventative
3 tool. For purposes of this Section, "low-dose mammography"
4 means the x-ray examination of the breast using equipment
5 dedicated specifically for mammography, including the x-ray
6 tube, filter, compression device, and image receptor, with an
7 average radiation exposure delivery of less than one rad per
8 breast for 2 views of an average size breast. The term also
9 includes digital mammography and includes breast
10 tomosynthesis. As used in this Section, the term "breast
11 tomosynthesis" means a radiologic procedure that involves the
12 acquisition of projection images over the stationary breast to
13 produce cross-sectional digital three-dimensional images of
14 the breast. If, at any time, the Secretary of the United States
15 Department of Health and Human Services, or its successor
16 agency, promulgates rules or regulations to be published in the
17 Federal Register or publishes a comment in the Federal Register
18 or issues an opinion, guidance, or other action that would
19 require the State, pursuant to any provision of the Patient
20 Protection and Affordable Care Act (Public Law 111-148),
21 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
22 successor provision, to defray the cost of any coverage for
23 breast tomosynthesis outlined in this paragraph, then the
24 requirement that an insurer cover breast tomosynthesis is
25 inoperative other than any such coverage authorized under
26 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and

1 the State shall not assume any obligation for the cost of
2 coverage for breast tomosynthesis set forth in this paragraph.

3 On and after January 1, 2016, the Department shall ensure
4 that all networks of care for adult clients of the Department
5 include access to at least one breast imaging Center of Imaging
6 Excellence as certified by the American College of Radiology.

7 On and after January 1, 2012, providers participating in a
8 quality improvement program approved by the Department shall be
9 reimbursed for screening and diagnostic mammography at the same
10 rate as the Medicare program's rates, including the increased
11 reimbursement for digital mammography.

12 The Department shall convene an expert panel including
13 representatives of hospitals, free-standing mammography
14 facilities, and doctors, including radiologists, to establish
15 quality standards for mammography.

16 On and after January 1, 2017, providers participating in a
17 breast cancer treatment quality improvement program approved
18 by the Department shall be reimbursed for breast cancer
19 treatment at a rate that is no lower than 95% of the Medicare
20 program's rates for the data elements included in the breast
21 cancer treatment quality program.

22 The Department shall convene an expert panel, including
23 representatives of hospitals, free standing breast cancer
24 treatment centers, breast cancer quality organizations, and
25 doctors, including breast surgeons, reconstructive breast
26 surgeons, oncologists, and primary care providers to establish

1 quality standards for breast cancer treatment.

2 Subject to federal approval, the Department shall
3 establish a rate methodology for mammography at federally
4 qualified health centers and other encounter-rate clinics.
5 These clinics or centers may also collaborate with other
6 hospital-based mammography facilities. By January 1, 2016, the
7 Department shall report to the General Assembly on the status
8 of the provision set forth in this paragraph.

9 The Department shall establish a methodology to remind
10 women who are age-appropriate for screening mammography, but
11 who have not received a mammogram within the previous 18
12 months, of the importance and benefit of screening mammography.
13 The Department shall work with experts in breast cancer
14 outreach and patient navigation to optimize these reminders and
15 shall establish a methodology for evaluating their
16 effectiveness and modifying the methodology based on the
17 evaluation.

18 The Department shall establish a performance goal for
19 primary care providers with respect to their female patients
20 over age 40 receiving an annual mammogram. This performance
21 goal shall be used to provide additional reimbursement in the
22 form of a quality performance bonus to primary care providers
23 who meet that goal.

24 The Department shall devise a means of case-managing or
25 patient navigation for beneficiaries diagnosed with breast
26 cancer. This program shall initially operate as a pilot program

1 in areas of the State with the highest incidence of mortality
2 related to breast cancer. At least one pilot program site shall
3 be in the metropolitan Chicago area and at least one site shall
4 be outside the metropolitan Chicago area. On or after July 1,
5 2016, the pilot program shall be expanded to include one site
6 in western Illinois, one site in southern Illinois, one site in
7 central Illinois, and 4 sites within metropolitan Chicago. An
8 evaluation of the pilot program shall be carried out measuring
9 health outcomes and cost of care for those served by the pilot
10 program compared to similarly situated patients who are not
11 served by the pilot program.

12 The Department shall require all networks of care to
13 develop a means either internally or by contract with experts
14 in navigation and community outreach to navigate cancer
15 patients to comprehensive care in a timely fashion. The
16 Department shall require all networks of care to include access
17 for patients diagnosed with cancer to at least one academic
18 commission on cancer-accredited cancer program as an
19 in-network covered benefit.

20 Any medical or health care provider shall immediately
21 recommend, to any pregnant woman who is being provided prenatal
22 services and is suspected of drug abuse or is addicted as
23 defined in the Alcoholism and Other Drug Abuse and Dependency
24 Act, referral to a local substance abuse treatment provider
25 licensed by the Department of Human Services or to a licensed
26 hospital which provides substance abuse treatment services.

1 The Department of Healthcare and Family Services shall assure
2 coverage for the cost of treatment of the drug abuse or
3 addiction for pregnant recipients in accordance with the
4 Illinois Medicaid Program in conjunction with the Department of
5 Human Services.

6 All medical providers providing medical assistance to
7 pregnant women under this Code shall receive information from
8 the Department on the availability of services under the Drug
9 Free Families with a Future or any comparable program providing
10 case management services for addicted women, including
11 information on appropriate referrals for other social services
12 that may be needed by addicted women in addition to treatment
13 for addiction.

14 The Illinois Department, in cooperation with the
15 Departments of Human Services (as successor to the Department
16 of Alcoholism and Substance Abuse) and Public Health, through a
17 public awareness campaign, may provide information concerning
18 treatment for alcoholism and drug abuse and addiction, prenatal
19 health care, and other pertinent programs directed at reducing
20 the number of drug-affected infants born to recipients of
21 medical assistance.

22 Neither the Department of Healthcare and Family Services
23 nor the Department of Human Services shall sanction the
24 recipient solely on the basis of her substance abuse.

25 The Illinois Department shall establish such regulations
26 governing the dispensing of health services under this Article

1 as it shall deem appropriate. The Department should seek the
2 advice of formal professional advisory committees appointed by
3 the Director of the Illinois Department for the purpose of
4 providing regular advice on policy and administrative matters,
5 information dissemination and educational activities for
6 medical and health care providers, and consistency in
7 procedures to the Illinois Department.

8 The Illinois Department may develop and contract with
9 Partnerships of medical providers to arrange medical services
10 for persons eligible under Section 5-2 of this Code.
11 Implementation of this Section may be by demonstration projects
12 in certain geographic areas. The Partnership shall be
13 represented by a sponsor organization. The Department, by rule,
14 shall develop qualifications for sponsors of Partnerships.
15 Nothing in this Section shall be construed to require that the
16 sponsor organization be a medical organization.

17 The sponsor must negotiate formal written contracts with
18 medical providers for physician services, inpatient and
19 outpatient hospital care, home health services, treatment for
20 alcoholism and substance abuse, and other services determined
21 necessary by the Illinois Department by rule for delivery by
22 Partnerships. Physician services must include prenatal and
23 obstetrical care. The Illinois Department shall reimburse
24 medical services delivered by Partnership providers to clients
25 in target areas according to provisions of this Article and the
26 Illinois Health Finance Reform Act, except that:

1 (1) Physicians participating in a Partnership and
2 providing certain services, which shall be determined by
3 the Illinois Department, to persons in areas covered by the
4 Partnership may receive an additional surcharge for such
5 services.

6 (2) The Department may elect to consider and negotiate
7 financial incentives to encourage the development of
8 Partnerships and the efficient delivery of medical care.

9 (3) Persons receiving medical services through
10 Partnerships may receive medical and case management
11 services above the level usually offered through the
12 medical assistance program.

13 Medical providers shall be required to meet certain
14 qualifications to participate in Partnerships to ensure the
15 delivery of high quality medical services. These
16 qualifications shall be determined by rule of the Illinois
17 Department and may be higher than qualifications for
18 participation in the medical assistance program. Partnership
19 sponsors may prescribe reasonable additional qualifications
20 for participation by medical providers, only with the prior
21 written approval of the Illinois Department.

22 Nothing in this Section shall limit the free choice of
23 practitioners, hospitals, and other providers of medical
24 services by clients. In order to ensure patient freedom of
25 choice, the Illinois Department shall immediately promulgate
26 all rules and take all other necessary actions so that provided

1 services may be accessed from therapeutically certified
2 optometrists to the full extent of the Illinois Optometric
3 Practice Act of 1987 without discriminating between service
4 providers.

5 The Department shall apply for a waiver from the United
6 States Health Care Financing Administration to allow for the
7 implementation of Partnerships under this Section.

8 The Illinois Department shall require health care
9 providers to maintain records that document the medical care
10 and services provided to recipients of Medical Assistance under
11 this Article. Such records must be retained for a period of not
12 less than 6 years from the date of service or as provided by
13 applicable State law, whichever period is longer, except that
14 if an audit is initiated within the required retention period
15 then the records must be retained until the audit is completed
16 and every exception is resolved. The Illinois Department shall
17 require health care providers to make available, when
18 authorized by the patient, in writing, the medical records in a
19 timely fashion to other health care providers who are treating
20 or serving persons eligible for Medical Assistance under this
21 Article. All dispensers of medical services shall be required
22 to maintain and retain business and professional records
23 sufficient to fully and accurately document the nature, scope,
24 details and receipt of the health care provided to persons
25 eligible for medical assistance under this Code, in accordance
26 with regulations promulgated by the Illinois Department. The

1 rules and regulations shall require that proof of the receipt
2 of prescription drugs, dentures, prosthetic devices and
3 eyeglasses by eligible persons under this Section accompany
4 each claim for reimbursement submitted by the dispenser of such
5 medical services. No such claims for reimbursement shall be
6 approved for payment by the Illinois Department without such
7 proof of receipt, unless the Illinois Department shall have put
8 into effect and shall be operating a system of post-payment
9 audit and review which shall, on a sampling basis, be deemed
10 adequate by the Illinois Department to assure that such drugs,
11 dentures, prosthetic devices and eyeglasses for which payment
12 is being made are actually being received by eligible
13 recipients. Within 90 days after September 16, 1984 (the
14 effective date of Public Act 83-1439), the Illinois Department
15 shall establish a current list of acquisition costs for all
16 prosthetic devices and any other items recognized as medical
17 equipment and supplies reimbursable under this Article and
18 shall update such list on a quarterly basis, except that the
19 acquisition costs of all prescription drugs shall be updated no
20 less frequently than every 30 days as required by Section
21 5-5.12.

22 The rules and regulations of the Illinois Department shall
23 require that a written statement including the required opinion
24 of a physician shall accompany any claim for reimbursement for
25 abortions, or induced miscarriages or premature births. This
26 statement shall indicate what procedures were used in providing

1 such medical services.

2 Notwithstanding any other law to the contrary, the Illinois
3 Department shall, within 365 days after July 22, 2013 (the
4 effective date of Public Act 98-104), establish procedures to
5 permit skilled care facilities licensed under the Nursing Home
6 Care Act to submit monthly billing claims for reimbursement
7 purposes. Following development of these procedures, the
8 Department shall, by July 1, 2016, test the viability of the
9 new system and implement any necessary operational or
10 structural changes to its information technology platforms in
11 order to allow for the direct acceptance and payment of nursing
12 home claims.

13 Notwithstanding any other law to the contrary, the Illinois
14 Department shall, within 365 days after August 15, 2014 (the
15 effective date of Public Act 98-963), establish procedures to
16 permit ID/DD facilities licensed under the ID/DD Community Care
17 Act and MC/DD facilities licensed under the MC/DD Act to submit
18 monthly billing claims for reimbursement purposes. Following
19 development of these procedures, the Department shall have an
20 additional 365 days to test the viability of the new system and
21 to ensure that any necessary operational or structural changes
22 to its information technology platforms are implemented.

23 The Illinois Department shall require all dispensers of
24 medical services, other than an individual practitioner or
25 group of practitioners, desiring to participate in the Medical
26 Assistance program established under this Article to disclose

1 all financial, beneficial, ownership, equity, surety or other
2 interests in any and all firms, corporations, partnerships,
3 associations, business enterprises, joint ventures, agencies,
4 institutions or other legal entities providing any form of
5 health care services in this State under this Article.

6 The Illinois Department may require that all dispensers of
7 medical services desiring to participate in the medical
8 assistance program established under this Article disclose,
9 under such terms and conditions as the Illinois Department may
10 by rule establish, all inquiries from clients and attorneys
11 regarding medical bills paid by the Illinois Department, which
12 inquiries could indicate potential existence of claims or liens
13 for the Illinois Department.

14 Enrollment of a vendor shall be subject to a provisional
15 period and shall be conditional for one year. During the period
16 of conditional enrollment, the Department may terminate the
17 vendor's eligibility to participate in, or may disenroll the
18 vendor from, the medical assistance program without cause.
19 Unless otherwise specified, such termination of eligibility or
20 disenrollment is not subject to the Department's hearing
21 process. However, a disenrolled vendor may reapply without
22 penalty.

23 The Department has the discretion to limit the conditional
24 enrollment period for vendors based upon category of risk of
25 the vendor.

26 Prior to enrollment and during the conditional enrollment

1 period in the medical assistance program, all vendors shall be
2 subject to enhanced oversight, screening, and review based on
3 the risk of fraud, waste, and abuse that is posed by the
4 category of risk of the vendor. The Illinois Department shall
5 establish the procedures for oversight, screening, and review,
6 which may include, but need not be limited to: criminal and
7 financial background checks; fingerprinting; license,
8 certification, and authorization verifications; unscheduled or
9 unannounced site visits; database checks; prepayment audit
10 reviews; audits; payment caps; payment suspensions; and other
11 screening as required by federal or State law.

12 The Department shall define or specify the following: (i)
13 by provider notice, the "category of risk of the vendor" for
14 each type of vendor, which shall take into account the level of
15 screening applicable to a particular category of vendor under
16 federal law and regulations; (ii) by rule or provider notice,
17 the maximum length of the conditional enrollment period for
18 each category of risk of the vendor; and (iii) by rule, the
19 hearing rights, if any, afforded to a vendor in each category
20 of risk of the vendor that is terminated or disenrolled during
21 the conditional enrollment period.

22 To be eligible for payment consideration, a vendor's
23 payment claim or bill, either as an initial claim or as a
24 resubmitted claim following prior rejection, must be received
25 by the Illinois Department, or its fiscal intermediary, no
26 later than 180 days after the latest date on the claim on which

1 medical goods or services were provided, with the following
2 exceptions:

3 (1) In the case of a provider whose enrollment is in
4 process by the Illinois Department, the 180-day period
5 shall not begin until the date on the written notice from
6 the Illinois Department that the provider enrollment is
7 complete.

8 (2) In the case of errors attributable to the Illinois
9 Department or any of its claims processing intermediaries
10 which result in an inability to receive, process, or
11 adjudicate a claim, the 180-day period shall not begin
12 until the provider has been notified of the error.

13 (3) In the case of a provider for whom the Illinois
14 Department initiates the monthly billing process.

15 (4) In the case of a provider operated by a unit of
16 local government with a population exceeding 3,000,000
17 when local government funds finance federal participation
18 for claims payments.

19 For claims for services rendered during a period for which
20 a recipient received retroactive eligibility, claims must be
21 filed within 180 days after the Department determines the
22 applicant is eligible. For claims for which the Illinois
23 Department is not the primary payer, claims must be submitted
24 to the Illinois Department within 180 days after the final
25 adjudication by the primary payer.

26 In the case of long term care facilities, within 5 days of

1 receipt by the facility of required prescreening information,
2 data for new admissions shall be entered into the Medical
3 Electronic Data Interchange (MEDI) or the Recipient
4 Eligibility Verification (REV) System or successor system, and
5 within 15 days of receipt by the facility of required
6 prescreening information, admission documents shall be
7 submitted through MEDI or REV or shall be submitted directly to
8 the Department of Human Services using required admission
9 forms. Effective September 1, 2014, admission documents,
10 including all prescreening information, must be submitted
11 through MEDI or REV. Confirmation numbers assigned to an
12 accepted transaction shall be retained by a facility to verify
13 timely submittal. Once an admission transaction has been
14 completed, all resubmitted claims following prior rejection
15 are subject to receipt no later than 180 days after the
16 admission transaction has been completed.

17 Claims that are not submitted and received in compliance
18 with the foregoing requirements shall not be eligible for
19 payment under the medical assistance program, and the State
20 shall have no liability for payment of those claims.

21 To the extent consistent with applicable information and
22 privacy, security, and disclosure laws, State and federal
23 agencies and departments shall provide the Illinois Department
24 access to confidential and other information and data necessary
25 to perform eligibility and payment verifications and other
26 Illinois Department functions. This includes, but is not

1 limited to: information pertaining to licensure;
2 certification; earnings; immigration status; citizenship; wage
3 reporting; unearned and earned income; pension income;
4 employment; supplemental security income; social security
5 numbers; National Provider Identifier (NPI) numbers; the
6 National Practitioner Data Bank (NPDB); program and agency
7 exclusions; taxpayer identification numbers; tax delinquency;
8 corporate information; and death records.

9 The Illinois Department shall enter into agreements with
10 State agencies and departments, and is authorized to enter into
11 agreements with federal agencies and departments, under which
12 such agencies and departments shall share data necessary for
13 medical assistance program integrity functions and oversight.
14 The Illinois Department shall develop, in cooperation with
15 other State departments and agencies, and in compliance with
16 applicable federal laws and regulations, appropriate and
17 effective methods to share such data. At a minimum, and to the
18 extent necessary to provide data sharing, the Illinois
19 Department shall enter into agreements with State agencies and
20 departments, and is authorized to enter into agreements with
21 federal agencies and departments, including but not limited to:
22 the Secretary of State; the Department of Revenue; the
23 Department of Public Health; the Department of Human Services;
24 and the Department of Financial and Professional Regulation.

25 Beginning in fiscal year 2013, the Illinois Department
26 shall set forth a request for information to identify the

1 benefits of a pre-payment, post-adjudication, and post-edit
2 claims system with the goals of streamlining claims processing
3 and provider reimbursement, reducing the number of pending or
4 rejected claims, and helping to ensure a more transparent
5 adjudication process through the utilization of: (i) provider
6 data verification and provider screening technology; and (ii)
7 clinical code editing; and (iii) pre-pay, pre- or
8 post-adjudicated predictive modeling with an integrated case
9 management system with link analysis. Such a request for
10 information shall not be considered as a request for proposal
11 or as an obligation on the part of the Illinois Department to
12 take any action or acquire any products or services.

13 The Illinois Department shall establish policies,
14 procedures, standards and criteria by rule for the acquisition,
15 repair and replacement of orthotic and prosthetic devices and
16 durable medical equipment. Such rules shall provide, but not be
17 limited to, the following services: (1) immediate repair or
18 replacement of such devices by recipients; and (2) rental,
19 lease, purchase or lease-purchase of durable medical equipment
20 in a cost-effective manner, taking into consideration the
21 recipient's medical prognosis, the extent of the recipient's
22 needs, and the requirements and costs for maintaining such
23 equipment. Subject to prior approval, such rules shall enable a
24 recipient to temporarily acquire and use alternative or
25 substitute devices or equipment pending repairs or
26 replacements of any device or equipment previously authorized

1 for such recipient by the Department. Notwithstanding any
2 provision of Section 5-5f to the contrary, the Department may,
3 by rule, exempt certain replacement wheelchair parts from prior
4 approval and, for wheelchairs, wheelchair parts, wheelchair
5 accessories, and related seating and positioning items,
6 determine the wholesale price by methods other than actual
7 acquisition costs.

8 The Department shall require, by rule, all providers of
9 durable medical equipment to be accredited by an accreditation
10 organization approved by the federal Centers for Medicare and
11 Medicaid Services and recognized by the Department in order to
12 bill the Department for providing durable medical equipment to
13 recipients. No later than 15 months after the effective date of
14 the rule adopted pursuant to this paragraph, all providers must
15 meet the accreditation requirement.

16 The Department shall execute, relative to the nursing home
17 prescreening project, written inter-agency agreements with the
18 Department of Human Services and the Department on Aging, to
19 effect the following: (i) intake procedures and common
20 eligibility criteria for those persons who are receiving
21 non-institutional services; and (ii) the establishment and
22 development of non-institutional services in areas of the State
23 where they are not currently available or are undeveloped; and
24 ~~(iii) notwithstanding any other provision of law, subject to~~
25 ~~federal approval, on and after July 1, 2012, an increase in the~~
26 ~~determination of need (DON) scores from 29 to 37 for applicants~~

1 ~~for institutional and home and community based long term care;~~
2 ~~if and only if federal approval is not granted, the Department~~
3 ~~may, in conjunction with other affected agencies, implement~~
4 ~~utilization controls or changes in benefit packages to~~
5 ~~effectuate a similar savings amount for this population; and~~
6 ~~(iv)~~ no later than July 1, 2013, minimum level of care
7 eligibility criteria for institutional and home and
8 community-based long term care; and (iv) ~~(v)~~ no later than
9 October 1, 2013, establish procedures to permit long term care
10 providers access to eligibility scores for individuals with an
11 admission date who are seeking or receiving services from the
12 long term care provider. In order to select the minimum level
13 of care eligibility criteria, the Governor shall establish a
14 workgroup that includes affected agency representatives and
15 stakeholders representing the institutional and home and
16 community-based long term care interests. This Section shall
17 not restrict the Department from implementing lower level of
18 care eligibility criteria for community-based services in
19 circumstances where federal approval has been granted.
20 Individuals with a score of 29 or higher based on the
21 determination of need (DON) assessment tool shall be eligible
22 to receive institutional and home and community-based long term
23 care services until the State receives federal approval and
24 implements an updated assessment tool, and those individuals
25 are found to be ineligible under that updated assessment tool.
26 Anyone determined to be ineligible for services due to the

1 updated assessment tool shall continue to be eligible for
2 services for at least one year following that determination and
3 must be reassessed no earlier than 11 months after that
4 determination. The Department must adopt rules through the
5 regular rulemaking process regarding the updated assessment
6 tool, and shall not adopt emergency or peremptory rules
7 regarding the updated assessment tool. The State shall not
8 implement an updated assessment tool that causes more than 1%
9 of then-current recipients to lose eligibility. No individual
10 receiving care in an institutional setting shall be
11 involuntarily discharged as the result of the updated
12 assessment tool until a transition plan has been developed by
13 the Department on Aging or its designee and all care identified
14 in the transition plan is available to the resident immediately
15 upon discharge.

16 The Illinois Department shall develop and operate, in
17 cooperation with other State Departments and agencies and in
18 compliance with applicable federal laws and regulations,
19 appropriate and effective systems of health care evaluation and
20 programs for monitoring of utilization of health care services
21 and facilities, as it affects persons eligible for medical
22 assistance under this Code.

23 The Illinois Department shall report annually to the
24 General Assembly, no later than the second Friday in April of
25 1979 and each year thereafter, in regard to:

26 (a) actual statistics and trends in utilization of

1 medical services by public aid recipients;

2 (b) actual statistics and trends in the provision of
3 the various medical services by medical vendors;

4 (c) current rate structures and proposed changes in
5 those rate structures for the various medical vendors; and

6 (d) efforts at utilization review and control by the
7 Illinois Department.

8 The period covered by each report shall be the 3 years
9 ending on the June 30 prior to the report. The report shall
10 include suggested legislation for consideration by the General
11 Assembly. The filing of one copy of the report with the
12 Speaker, one copy with the Minority Leader and one copy with
13 the Clerk of the House of Representatives, one copy with the
14 President, one copy with the Minority Leader and one copy with
15 the Secretary of the Senate, one copy with the Legislative
16 Research Unit, and such additional copies with the State
17 Government Report Distribution Center for the General Assembly
18 as is required under paragraph (t) of Section 7 of the State
19 Library Act shall be deemed sufficient to comply with this
20 Section.

21 Rulemaking authority to implement Public Act 95-1045, if
22 any, is conditioned on the rules being adopted in accordance
23 with all provisions of the Illinois Administrative Procedure
24 Act and all rules and procedures of the Joint Committee on
25 Administrative Rules; any purported rule not so adopted, for
26 whatever reason, is unauthorized.

1 On and after July 1, 2012, the Department shall reduce any
2 rate of reimbursement for services or other payments or alter
3 any methodologies authorized by this Code to reduce any rate of
4 reimbursement for services or other payments in accordance with
5 Section 5-5e.

6 Because kidney transplantation can be an appropriate, cost
7 effective alternative to renal dialysis when medically
8 necessary and notwithstanding the provisions of Section 1-11 of
9 this Code, beginning October 1, 2014, the Department shall
10 cover kidney transplantation for noncitizens with end-stage
11 renal disease who are not eligible for comprehensive medical
12 benefits, who meet the residency requirements of Section 5-3 of
13 this Code, and who would otherwise meet the financial
14 requirements of the appropriate class of eligible persons under
15 Section 5-2 of this Code. To qualify for coverage of kidney
16 transplantation, such person must be receiving emergency renal
17 dialysis services covered by the Department. Providers under
18 this Section shall be prior approved and certified by the
19 Department to perform kidney transplantation and the services
20 under this Section shall be limited to services associated with
21 kidney transplantation.

22 Notwithstanding any other provision of this Code to the
23 contrary, on or after July 1, 2015, all FDA approved forms of
24 medication assisted treatment prescribed for the treatment of
25 alcohol dependence or treatment of opioid dependence shall be
26 covered under both fee for service and managed care medical

1 assistance programs for persons who are otherwise eligible for
2 medical assistance under this Article and shall not be subject
3 to any (1) utilization control, other than those established
4 under the American Society of Addiction Medicine patient
5 placement criteria, (2) prior authorization mandate, or (3)
6 lifetime restriction limit mandate.

7 On or after July 1, 2015, opioid antagonists prescribed for
8 the treatment of an opioid overdose, including the medication
9 product, administration devices, and any pharmacy fees related
10 to the dispensing and administration of the opioid antagonist,
11 shall be covered under the medical assistance program for
12 persons who are otherwise eligible for medical assistance under
13 this Article. As used in this Section, "opioid antagonist"
14 means a drug that binds to opioid receptors and blocks or
15 inhibits the effect of opioids acting on those receptors,
16 including, but not limited to, naloxone hydrochloride or any
17 other similarly acting drug approved by the U.S. Food and Drug
18 Administration.

19 Upon federal approval, the Department shall provide
20 coverage and reimbursement for all drugs that are approved for
21 marketing by the federal Food and Drug Administration and that
22 are recommended by the federal Public Health Service or the
23 United States Centers for Disease Control and Prevention for
24 pre-exposure prophylaxis and related pre-exposure prophylaxis
25 services, including, but not limited to, HIV and sexually
26 transmitted infection screening, treatment for sexually

1 transmitted infections, medical monitoring, assorted labs, and
2 counseling to reduce the likelihood of HIV infection among
3 individuals who are not infected with HIV but who are at high
4 risk of HIV infection.

5 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
6 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
7 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
8 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
9 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section
10 20 of P.A. 99-588 for the effective date of P.A. 99-407);
11 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff.
12 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895,
13 eff. 1-1-17; revised 9-20-16.)

14 (305 ILCS 5/5-5.01a)

15 Sec. 5-5.01a. Supportive living facilities program. The
16 Department shall establish and provide oversight for a program
17 of supportive living facilities that seek to promote resident
18 independence, dignity, respect, and well-being in the most
19 cost-effective manner.

20 A supportive living facility is either a free-standing
21 facility or a distinct physical and operational entity within a
22 nursing facility. A supportive living facility integrates
23 housing with health, personal care, and supportive services and
24 is a designated setting that offers residents their own
25 separate, private, and distinct living units.

1 Sites for the operation of the program shall be selected by
2 the Department based upon criteria that may include the need
3 for services in a geographic area, the availability of funding,
4 and the site's ability to meet the standards.

5 Beginning July 1, 2014, subject to federal approval, the
6 Medicaid rates for supportive living facilities shall be equal
7 to the supportive living facility Medicaid rate effective on
8 June 30, 2014 increased by 8.85%. Once the assessment imposed
9 at Article V-G of this Code is determined to be a permissible
10 tax under Title XIX of the Social Security Act, the Department
11 shall increase the Medicaid rates for supportive living
12 facilities effective on July 1, 2014 by 9.09%. The Department
13 shall apply this increase retroactively to coincide with the
14 imposition of the assessment in Article V-G of this Code in
15 accordance with the approval for federal financial
16 participation by the Centers for Medicare and Medicaid
17 Services.

18 The Department may adopt rules to implement this Section.
19 Rules that establish or modify the services, standards, and
20 conditions for participation in the program shall be adopted by
21 the Department in consultation with the Department on Aging,
22 the Department of Rehabilitation Services, and the Department
23 of Mental Health and Developmental Disabilities (or their
24 successor agencies).

25 Facilities or distinct parts of facilities which are
26 selected as supportive living facilities and are in good

1 standing with the Department's rules are exempt from the
2 provisions of the Nursing Home Care Act and the Illinois Health
3 Facilities Planning Act.

4 Individuals with a score of 29 or higher based on the
5 determination of need (DON) assessment tool shall be eligible
6 to receive institutional and home and community-based long term
7 care services until the State receives federal approval and
8 implements an updated assessment tool, and those individuals
9 are found to be ineligible under that updated assessment tool.
10 Anyone determined to be ineligible for services due to the
11 updated assessment tool shall continue to be eligible for
12 services for at least one year following that determination and
13 must be reassessed no earlier than 11 months after that
14 determination. The Department must adopt rules through the
15 regular rulemaking process regarding the updated assessment
16 tool, and shall not adopt emergency or peremptory rules
17 regarding the updated assessment tool. The State shall not
18 implement an updated assessment tool that causes more than 1%
19 of then-current recipients to lose eligibility. No individual
20 receiving care in an institutional setting shall be
21 involuntarily discharged as the result of the updated
22 assessment tool until a transition plan has been developed by
23 the Department on Aging or its designee and all care identified
24 in the transition plan is available to the resident immediately
25 upon discharge.

26 (Source: P.A. 98-651, eff. 6-16-14.)

1 Section 99. Effective date. This Act takes effect upon
2 becoming law.