HB2496

LRB101 10944 KTG 56118 b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB2496

by Rep. LaToya Greenwood

SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Act on the Aging, the Disabled Persons Rehabilitation Act, and the Illinois Public Aid Code. Regarding services under the Community Care Program (CCP), the Home Services Program, the supportive living facilities program, and the nursing home prescreening project, provides that individuals with a score of 29 or higher based on the determination of need assessment tool shall be eligible to receive institutional and home and community-based long term care services until the State receives federal approval and implements an updated assessment tool, and those individuals are found to be ineligible under that updated assessment tool. Requires the Department on Aging and the Departments of Human Services and Healthcare and Family Services to adopt rules, but not emergency rules, regarding the updated assessment tool. Contains provisions concerning continued eligibility for persons made ineligible for services under the updated assessment tool. Amends the Illinois Act on the Aging. Prohibits the Department on Aging from adopting any rule that: (i) restricts eligibility under CCP to persons who qualify for medical assistance; or (ii) establishes a separate program of home and community-based long term care services for persons eligible for CCP services but not eligible for medical assistance. Prohibits the Department from increasing copayment levels under CCP to those levels in effect on January 1, 2016. Amends the Illinois Public Aid Code. Deletes a provision concerning an increase in the determination of need scores, on and after July 1, 2012, from 29 to 37. Amends the Nursing Home Care Act. Prohibits the involuntary discharge of an individual receiving care in an institutional setting as the result of the updated assessment tool until a transition plan has been developed. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning State government.

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;

(g) education in self-care;

(h) personal care services;

(i) adult day health services;

(j) habilitation services;

(k) respite care;

(k-5) community reintegration services;

(k-6) flexible senior services;

(k-7) medication management;

(k-8) emergency home response;

(l) other nonmedical social services that may enable the person to become self-supporting; or

(m) clearinghouse for information provided by senior citizen home owners who want to rent rooms to or share living space with other senior citizens.

Individuals who meet the following criteria shall have equal access to services under the Community Care Program: ~~The Department shall establish eligibility standards for such services.~~

(a) are 60 years old or older;

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

(c) are residents of Illinois;

(d) have nonexempt assets of $17,500 or less; nonexempt assets do not include home, car, or personal furnishings; and

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

training shall be at the Department's discretion.

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

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

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

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

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

(2) ensuring that care plans contain the services that eligible participants need based on the number of days in a month, not limited to specific blocks of time, as identified by the comprehensive assessment tool selected by the Department for use statewide, not to exceed the 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

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

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

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

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

Beginning on the effective date of this amendatory Act of 1991, no person may perform chore/housekeeping and home care aide services under a program authorized by this Section unless that person has been issued a certificate of pre-service to do 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 as required by
26 Section 3.1 of the General Assembly Organization Act and filing

1 such additional copies with the State Government Report
2 Distribution Center for the General Assembly as is required
3 under paragraph (t) of Section 7 of the State Library Act.
4 Those persons previously found eligible for receiving
5 non-institutional services whose services were discontinued
6 under the Emergency Budget Act of Fiscal Year 1992, and who do
7 not meet the eligibility standards in effect on or after July
8 1, 1992, shall remain ineligible on and after July 1, 1992.
9 Those persons previously not required to cost-share and who
10 were required to cost-share effective March 1, 1992, shall
11 continue to meet cost-share requirements on and after July 1,
12 1992. Beginning July 1, 1992, all clients will be required to
13 meet eligibility, cost-share, and other requirements and will
14 have services discontinued or altered when they fail to meet
15 these requirements.
16 For the purposes of this Section, "flexible senior
17 services" refers to services that require one-time or periodic
18 expenditures including, but not limited to, respite care, home
19 modification, assistive technology, housing assistance, and
20 transportation.
21 The Department shall implement an electronic service
22 verification based on global positioning systems or other
23 cost-effective technology for the Community Care Program no
24 later than January 1, 2014.
25 ~~The Department shall require, as a condition of~~
26 ~~eligibility, enrollment in the medical assistance program~~

~~under Article V of the Illinois Public Aid Code (i) beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has reported that the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-27 of the Illinois State Auditing Act.~~

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

~~The Department shall implement co-payments for the Community Care Program at the federally allowable maximum level (i) beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has reported that the Department has not undertaken the required actions listed in the report required by subsection~~

~~(a) of Section 2-27 of the Illinois State Auditing Act.~~

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

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

In regard to community care providers, failure to comply with Department on Aging policies shall be cause for disciplinary action, including, but not limited to, disqualification from serving Community Care Program clients. Each provider, upon submission of any bill or invoice to the Department for payment for services rendered, shall include a notarized statement, under penalty of perjury pursuant to Section 1-109 of the Code of Civil Procedure, that the provider has complied with all Department policies.

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

6 Within 30 days after July 6, 2017 (the effective date of
7 Public Act 100-23), rates shall be increased to $18.29 per
8 hour, for the purpose of increasing, by at least $.72 per hour,
9 the wages paid by those vendors to their employees who provide
10 homemaker services. The Department shall pay an enhanced rate
11 under the Community Care Program to those in-home service
12 provider agencies that offer health insurance coverage as a
13 benefit to their direct service worker employees consistent
14 with the mandates of Public Act 95-713. For State fiscal years
15 2018 and 2019, the enhanced rate shall be $1.77 per hour. The
16 rate shall be adjusted using actuarial analysis based on the
17 cost of care, but shall not be set below $1.77 per hour. The
18 Department shall adopt rules, including emergency rules under
19 subsections (y) and (bb) of Section 5-45 of the Illinois
20 Administrative Procedure Act, to implement the provisions of
21 this paragraph.

22 The General Assembly finds it necessary to authorize an
23 aggressive Medicaid enrollment initiative designed to maximize
24 federal Medicaid funding for the Community Care Program which
25 produces significant savings for the State of Illinois. The
26 Department on Aging shall establish and implement a Community

1 Care Program Medicaid Initiative. Under the Initiative, the
2 Department on Aging shall, at a minimum: (i) provide an
3 enhanced rate to adequately compensate care coordination units
4 to enroll eligible Community Care Program clients into
5 Medicaid; (ii) use recommendations from a stakeholder
6 committee on how best to implement the Initiative; and (iii)
7 establish requirements for State agencies to make enrollment in
8 the State's Medical Assistance program easier for seniors.

9 The Community Care Program Medicaid Enrollment Oversight
10 Subcommittee is created as a subcommittee of the Older Adult
11 Services Advisory Committee established in Section 35 of the
12 Older Adult Services Act to make recommendations on how best to
13 increase the number of medical assistance recipients who are
14 enrolled in the Community Care Program. The Subcommittee shall
15 consist of all of the following persons who must be appointed
16 within 30 days after the effective date of this amendatory Act
17 of the 100th General Assembly:

18 (1) The Director of Aging, or his or her designee, who
19 shall serve as the chairperson of the Subcommittee.

20 (2) One representative of the Department of Healthcare
21 and Family Services, appointed by the Director of
22 Healthcare and Family Services.

23 (3) One representative of the Department of Human
24 Services, appointed by the Secretary of Human Services.

25 (4) One individual representing a care coordination
26 unit, appointed by the Director of Aging.

1 (5) One individual from a non-governmental statewide
2 organization that advocates for seniors, appointed by the
3 Director of Aging.
4 (6) One individual representing Area Agencies on
5 Aging, appointed by the Director of Aging.
6 (7) One individual from a statewide association
7 dedicated to Alzheimer's care, support, and research,
8 appointed by the Director of Aging.
9 (8) One individual from an organization that employs
10 persons who provide services under the Community Care
11 Program, appointed by the Director of Aging.
12 (9) One member of a trade or labor union representing
13 persons who provide services under the Community Care
14 Program, appointed by the Director of Aging.
15 (10) One member of the Senate, who shall serve as
16 co-chairperson, appointed by the President of the Senate.
17 (11) One member of the Senate, who shall serve as
18 co-chairperson, appointed by the Minority Leader of the
19 Senate.
20 (12) One member of the House of Representatives, who
21 shall serve as co-chairperson, appointed by the Speaker of
22 the House of Representatives.
23 (13) One member of the House of Representatives, who
24 shall serve as co-chairperson, appointed by the Minority
25 Leader of the House of Representatives.
26 (14) One individual appointed by a labor organization

representing frontline employees at the Department of Human Services.

The Subcommittee shall provide oversight to the Community Care Program Medicaid Initiative and shall meet quarterly. At each Subcommittee meeting the Department on Aging shall provide the following data sets to the Subcommittee: (A) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program and are enrolled in the State's Medical Assistance Program; (B) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program, but are not enrolled in the State's Medical Assistance Program; and (C) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program and are eligible for benefits under the State's Medical Assistance Program, but are not enrolled in the State's Medical Assistance Program. In addition to this data, the Department on Aging shall provide the Subcommittee with plans on how the Department on Aging will reduce the number of Illinois residents who are not enrolled in the State's Medical Assistance Program but who are eligible for medical assistance benefits. The Department on Aging shall enroll in the State's Medical Assistance Program those Illinois residents who receive services under the Community Care Program and are eligible for medical assistance benefits but are not enrolled in the State's Medicaid Assistance Program. The data

1 provided to the Subcommittee shall be made available to the
2 public via the Department on Aging's website.
3 The Department on Aging, with the involvement of the
4 Subcommittee, shall collaborate with the Department of Human
5 Services and the Department of Healthcare and Family Services
6 on how best to achieve the responsibilities of the Community
7 Care Program Medicaid Initiative.
8 The Department on Aging, the Department of Human Services,
9 and the Department of Healthcare and Family Services shall
10 coordinate and implement a streamlined process for seniors to
11 access benefits under the State's Medical Assistance Program.
12 The Subcommittee shall collaborate with the Department of
13 Human Services on the adoption of a uniform application
14 submission process. The Department of Human Services and any
15 other State agency involved with processing the medical
16 assistance application of any person enrolled in the Community
17 Care Program shall include the appropriate care coordination
18 unit in all communications related to the determination or
19 status of the application.
20 The Community Care Program Medicaid Initiative shall
21 provide targeted funding to care coordination units to help
22 seniors complete their applications for medical assistance
23 benefits. On and after July 1, 2019, care coordination units
24 shall receive no less than $200 per completed application.
25 The Community Care Program Medicaid Initiative shall cease
26 operation 5 years after the effective date of this amendatory

1 Act of the 100th General Assembly, after which the Subcommittee
2 shall dissolve.
3 (Source: P.A. 99-143, eff. 7-27-15; 100-23, eff. 7-6-17;
4 100-587, eff. 6-4-18; 100-1148, eff. 12-10-18.)

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

7 (20 ILCS 2405/3) (from Ch. 23, par. 3434)
8 Sec. 3. Powers and duties. The Department shall have the
9 powers and duties enumerated herein:
10 (a) To co-operate with the federal government in the
11 administration of the provisions of the federal
12 Rehabilitation Act of 1973, as amended, of the Workforce
13 Innovation and Opportunity Act, and of the federal Social
14 Security Act to the extent and in the manner provided in
15 these Acts.
16 (b) To prescribe and supervise such courses of
17 vocational training and provide such other services as may
18 be necessary for the habilitation and rehabilitation of
19 persons with one or more disabilities, including the
20 administrative activities under subsection (e) of this
21 Section, and to co-operate with State and local school
22 authorities and other recognized agencies engaged in
23 habilitation, rehabilitation and comprehensive
24 rehabilitation services; and to cooperate with the

1 Department of Children and Family Services regarding the
2 care and education of children with one or more
3 disabilities.
4 (c) (Blank).
5 (d) To report in writing, to the Governor, annually on
6 or before the first day of December, and at such other
7 times and in such manner and upon such subjects as the
8 Governor may require. The annual report shall contain (1) a
9 statement of the existing condition of comprehensive
10 rehabilitation services, habilitation and rehabilitation
11 in the State; (2) a statement of suggestions and
12 recommendations with reference to the development of
13 comprehensive rehabilitation services, habilitation and
14 rehabilitation in the State; and (3) an itemized statement
15 of the amounts of money received from federal, State and
16 other sources, and of the objects and purposes to which the
17 respective items of these several amounts have been
18 devoted.
19 (e) (Blank).
20 (f) To establish a program of services to prevent the
21 unnecessary institutionalization of persons in need of
22 long term care and who meet the criteria for blindness or
23 disability as defined by the Social Security Act, thereby
24 enabling them to remain in their own homes. Such preventive
25 services include any or all of the following:
26 (1) personal assistant services;

1 (2) homemaker services;
2 (3) home-delivered meals;
3 (4) adult day care services;
4 (5) respite care;
5 (6) home modification or assistive equipment;
6 (7) home health services;
7 (8) electronic home response;
8 (9) brain injury behavioral/cognitive services;
9 (10) brain injury habilitation;
10 (11) brain injury pre-vocational services; or
11 (12) brain injury supported employment.
12 The Department shall establish eligibility standards
13 for such services taking into consideration the unique
14 economic and social needs of the population for whom they
15 are to be provided. Such eligibility standards may be based
16 on the recipient's ability to pay for services; provided,
17 however, that any portion of a person's income that is
18 equal to or less than the "protected income" level shall
19 not be considered by the Department in determining
20 eligibility. The "protected income" level shall be
21 determined by the Department, shall never be less than the
22 federal poverty standard, and shall be adjusted each year
23 to reflect changes in the Consumer Price Index For All
24 Urban Consumers as determined by the United States
25 Department of Labor. The standards must provide that a
26 person may not have more than $10,000 in assets to be

1 eligible for the services, and the Department may increase
2 or decrease the asset limitation by rule. The Department
3 may not decrease the asset level below $10,000.

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.

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

24 The services shall be provided, as established by the
25 Department by rule, to eligible persons to prevent
26 unnecessary or premature institutionalization, to the

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

12 Except as otherwise provided in this paragraph,
13 personal assistants shall be paid at a rate negotiated
14 between the State and an exclusive representative of
15 personal assistants under a collective bargaining
16 agreement. In no case shall the Department pay personal
17 assistants an hourly wage that is less than the federal
18 minimum wage. Within 30 days after July 6, 2017 (the
19 effective date of Public Act 100-23), the hourly wage paid
20 to personal assistants and individual maintenance home
21 health workers shall be increased by $0.48 per hour.

22 Solely for the purposes of coverage under the Illinois
23 Public Labor Relations Act, personal assistants providing
24 services under the Department's Home Services Program
25 shall be considered to be public employees and the State of
26 Illinois shall be considered to be their employer as of

1 July 16, 2003 (the effective date of Public Act 93-204),
2 but not before. Solely for the purposes of coverage under
3 the Illinois Public Labor Relations Act, home care and home
4 health workers who function as personal assistants and
5 individual maintenance home health workers and who also
6 provide services under the Department's Home Services
7 Program shall be considered to be public employees, no
8 matter whether the State provides such services through
9 direct fee-for-service arrangements, with the assistance
10 of a managed care organization or other intermediary, or
11 otherwise, and the State of Illinois shall be considered to
12 be the employer of those persons as of January 29, 2013
13 (the effective date of Public Act 97-1158), but not before
14 except as otherwise provided under this subsection (f). The
15 State shall engage in collective bargaining with an
16 exclusive representative of home care and home health
17 workers who function as personal assistants and individual
18 maintenance home health workers working under the Home
19 Services Program concerning their terms and conditions of
20 employment that are within the State's control. Nothing in
21 this paragraph shall be understood to limit the right of
22 the persons receiving services defined in this Section to
23 hire and fire home care and home health workers who
24 function as personal assistants and individual maintenance
25 home health workers working under the Home Services Program
26 or to supervise them within the limitations set by the Home

1 Services Program. The State shall not be considered to be
2 the employer of home care and home health workers who
3 function as personal assistants and individual maintenance
4 home health workers working under the Home Services Program
5 for any purposes not specifically provided in Public Act
6 93-204 or Public Act 97-1158, including but not limited to,
7 purposes of vicarious liability in tort and purposes of
8 statutory retirement or health insurance benefits. Home
9 care and home health workers who function as personal
10 assistants and individual maintenance home health workers
11 and who also provide services under the Department's Home
12 Services Program shall not be covered by the State
13 Employees Group Insurance Act of 1971.

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

24 The Department is authorized to establish a system of
25 recipient cost-sharing for services provided under this
26 Section. The cost-sharing shall be based upon the

1 recipient's ability to pay for services, but in no case
2 shall the recipient's share exceed the actual cost of the
3 services provided. Protected income shall not be
4 considered by the Department in its determination of the
5 recipient's ability to pay a share of the cost of services.
6 The level of cost-sharing shall be adjusted each year to
7 reflect changes in the "protected income" level. The
8 Department shall deduct from the recipient's share of the
9 cost of services any money expended by the recipient for
10 disability-related expenses.

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

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

18 The Department shall submit an annual report on
19 programs and services provided under this Section. The
20 report shall be filed with the Governor and the General
21 Assembly on or before March 30 each year.

22 The requirement for reporting to the General Assembly
23 shall be satisfied by filing copies of the report as
24 required by Section 3.1 of the General Assembly
25 Organization Act, and filing additional copies with the
26 State Government Report Distribution Center for the

1 General Assembly as required under paragraph (t) of Section
2 7 of the State Library Act.
3 (g) To establish such subdivisions of the Department as
4 shall be desirable and assign to the various subdivisions
5 the responsibilities and duties placed upon the Department
6 by law.
7 (h) To cooperate and enter into any necessary
8 agreements with the Department of Employment Security for
9 the provision of job placement and job referral services to
10 clients of the Department, including job service
11 registration of such clients with Illinois Employment
12 Security offices and making job listings maintained by the
13 Department of Employment Security available to such
14 clients.
15 (i) To possess all powers reasonable and necessary for
16 the exercise and administration of the powers, duties and
17 responsibilities of the Department which are provided for
18 by law.
19 (j) (Blank).
20 (k) (Blank).
21 (l) To establish, operate, and maintain a Statewide
22 Housing Clearinghouse of information on available
23 government subsidized housing accessible to persons with
24 disabilities and available privately owned housing
25 accessible to persons with disabilities. The information
26 shall include, but not be limited to, the location, rental

1 requirements, access features and proximity to public
2 transportation of available housing. The Clearinghouse
3 shall consist of at least a computerized database for the
4 storage and retrieval of information and a separate or
5 shared toll free telephone number for use by those seeking
6 information from the Clearinghouse. Department offices and
7 personnel throughout the State shall also assist in the
8 operation of the Statewide Housing Clearinghouse.
9 Cooperation with local, State, and federal housing
10 managers shall be sought and extended in order to
11 frequently and promptly update the Clearinghouse's
12 information.

13 (m) To assure that the names and case records of
14 persons who received or are receiving services from the
15 Department, including persons receiving vocational
16 rehabilitation, home services, or other services, and
17 those attending one of the Department's schools or other
18 supervised facility shall be confidential and not be open
19 to the general public. Those case records and reports or
20 the information contained in those records and reports
21 shall be disclosed by the Director only to proper law
22 enforcement officials, individuals authorized by a court,
23 the General Assembly or any committee or commission of the
24 General Assembly, and other persons and for reasons as the
25 Director designates by rule. Disclosure by the Director may
26 be only in accordance with other applicable law.

(Source: P.A. 99-143, eff. 7-27-15; 100-23, eff. 7-6-17; 100-477, eff. 9-8-17; 100-587, eff. 6-4-18; 100-863, eff. 8-14-18; 100-1148, eff. 12-10-18.)

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

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

Sec. 3-402. Involuntary transfer or discharge.

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

(a) When an emergency transfer or discharge is ordered by the resident's attending physician because of the resident's health care needs.

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

(c) When an identified offender is within the

1 provisional admission period defined in Section 1-120.3.
2 If the Identified Offender Report and Recommendation
3 prepared under Section 2-201.6 shows that the identified
4 offender poses a serious threat or danger to the physical
5 safety of other residents, the facility staff, or facility
6 visitors in the admitting facility and the facility
7 determines that it is unable to provide a safe environment
8 for the other residents, the facility staff, or facility
9 visitors, the facility shall transfer or discharge the
10 identified offender within 3 days after its receipt of the
11 Identified Offender Report and Recommendation.
12 No individual receiving care in an institutional setting
13 shall be involuntarily discharged as the result of the updated
14 determination of need (DON) assessment tool as provided in
15 Section 5-5 of the Illinois Public Aid Code until a transition
16 plan has been developed by the Department on Aging or its
17 designee and all care identified in the transition plan is
18 available to the resident immediately upon discharge.
19 (Source: P.A. 96-1372, eff. 7-29-10.)

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

22 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)
23 Sec. 5-5. Medical services. The Illinois Department, by
24 rule, shall determine the quantity and quality of and the rate

1 of reimbursement for the medical assistance for which payment
2 will be authorized, and the medical services to be provided,
3 which may include all or part of the following: (1) inpatient
4 hospital services; (2) outpatient hospital services; (3) other
5 laboratory and X-ray services; (4) skilled nursing home
6 services; (5) physicians' services whether furnished in the
7 office, the patient's home, a hospital, a skilled nursing home,
8 or elsewhere; (6) medical care, or any other type of remedial
9 care furnished by licensed practitioners; (7) home health care
10 services; (8) private duty nursing service; (9) clinic
11 services; (10) dental services, including prevention and
12 treatment of periodontal disease and dental caries disease for
13 pregnant women, provided by an individual licensed to practice
14 dentistry or dental surgery; for purposes of this item (10),
15 "dental services" means diagnostic, preventive, or corrective
16 procedures provided by or under the supervision of a dentist in
17 the practice of his or her profession; (11) physical therapy
18 and related services; (12) prescribed drugs, dentures, and
19 prosthetic devices; and eyeglasses prescribed by a physician
20 skilled in the diseases of the eye, or by an optometrist,
21 whichever the person may select; (13) other diagnostic,
22 screening, preventive, and rehabilitative services, including
23 to ensure that the individual's need for intervention or
24 treatment of mental disorders or substance use disorders or
25 co-occurring mental health and substance use disorders is
26 determined using a uniform screening, assessment, and

1 evaluation process inclusive of criteria, for children and
2 adults; for purposes of this item (13), a uniform screening,
3 assessment, and evaluation process refers to a process that
4 includes an appropriate evaluation and, as warranted, a
5 referral; "uniform" does not mean the use of a singular
6 instrument, tool, or process that all must utilize; (14)
7 transportation and such other expenses as may be necessary;
8 (15) medical treatment of sexual assault survivors, as defined
9 in Section 1a of the Sexual Assault Survivors Emergency
10 Treatment Act, for injuries sustained as a result of the sexual
11 assault, including examinations and laboratory tests to
12 discover evidence which may be used in criminal proceedings
13 arising from the sexual assault; (16) the diagnosis and
14 treatment of sickle cell anemia; and (17) any other medical
15 care, and any other type of remedial care recognized under the
16 laws of this State. The term "any other type of remedial care"
17 shall include nursing care and nursing home service for persons
18 who rely on treatment by spiritual means alone through prayer
19 for healing.

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

Notwithstanding any other provision of this Code, reproductive health care that is otherwise legal in Illinois shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article.

Notwithstanding any other provision of this Code, the Illinois Department may not require, as a condition of payment for any laboratory test authorized under this Article, that a physician's handwritten signature appear on the laboratory test order form. The Illinois Department may, however, impose other appropriate requirements regarding laboratory test order documentation.

Upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan for this purpose, the Department shall authorize the Chicago Public Schools (CPS) to procure a vendor or vendors to manufacture eyeglasses for individuals enrolled in a school within the CPS system. CPS shall ensure that its vendor or vendors are enrolled as providers in the medical assistance program and in any capitated Medicaid managed care entity (MCE) serving individuals enrolled in a school within the CPS system. Under any contract procured under this provision, the vendor or vendors must serve only individuals enrolled in a school within the CPS system. Claims for services provided by CPS's vendor or vendors to recipients of benefits in the medical assistance program under this Code, the Children's Health Insurance Program, or the Covering ALL

KIDS Health Insurance Program shall be submitted to the Department or the MCE in which the individual is enrolled for payment and shall be reimbursed at the Department's or the MCE's established rates or rate methodologies for eyeglasses.

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

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

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

On and after July 1, 2018, the Department of Healthcare and Family Services shall provide dental services to any adult who is otherwise eligible for assistance under the medical assistance program. As used in this paragraph, "dental services" means diagnostic, preventative, restorative, or corrective procedures, including procedures and services for the prevention and treatment of periodontal disease and dental caries disease, provided by an individual who is licensed to practice dentistry or dental surgery or who is under the supervision of a dentist in the practice of his or her profession.

1 On and after July 1, 2018, targeted dental services, as set
2 forth in Exhibit D of the Consent Decree entered by the United
3 States District Court for the Northern District of Illinois,
4 Eastern Division, in the matter of Memisovski v. Maram, Case
5 No. 92 C 1982, that are provided to adults under the medical
6 assistance program shall be established at no less than the
7 rates set forth in the "New Rate" column in Exhibit D of the
8 Consent Decree for targeted dental services that are provided
9 to persons under the age of 18 under the medical assistance
10 program.

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

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

1 The Department of Healthcare and Family Services must
2 provide coverage and reimbursement for amino acid-based
3 elemental formulas, regardless of delivery method, for the
4 diagnosis and treatment of (i) eosinophilic disorders and (ii)
5 short bowel syndrome when the prescribing physician has issued
6 a written order stating that the amino acid-based elemental
7 formula is medically necessary.

8 The Illinois Department shall authorize the provision of,
9 and shall authorize payment for, screening by low-dose
10 mammography for the presence of occult breast cancer for women
11 35 years of age or older who are eligible for medical
12 assistance under this Article, as follows:

13 (A) A baseline mammogram for women 35 to 39 years of
14 age.

15 (B) An annual mammogram for women 40 years of age or
16 older.

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

22 (D) A comprehensive ultrasound screening and MRI of an
23 entire breast or breasts if a mammogram demonstrates
24 heterogeneous or dense breast tissue, when medically
25 necessary as determined by a physician licensed to practice
26 medicine in all of its branches.

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

1 breast tomosynthesis outlined in this paragraph, then the
2 requirement that an insurer cover breast tomosynthesis is
3 inoperative other than any such coverage authorized under
4 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
5 the State shall not assume any obligation for the cost of
6 coverage for breast tomosynthesis set forth in this paragraph.

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

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

16 The Department shall convene an expert panel including
17 representatives of hospitals, free-standing mammography
18 facilities, and doctors, including radiologists, to establish
19 quality standards for mammography.

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

26 The Department shall convene an expert panel, including

1 representatives of hospitals, free-standing breast cancer
2 treatment centers, breast cancer quality organizations, and
3 doctors, including breast surgeons, reconstructive breast
4 surgeons, oncologists, and primary care providers to establish
5 quality standards for breast cancer treatment.

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

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

22 The Department shall establish a performance goal for
23 primary care providers with respect to their female patients
24 over age 40 receiving an annual mammogram. This performance
25 goal shall be used to provide additional reimbursement in the
26 form of a quality performance bonus to primary care providers

who meet that goal.

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. On or after July 1, 2016, the pilot program shall be expanded to include one site in western Illinois, one site in southern Illinois, one site in central Illinois, and 4 sites within metropolitan Chicago. An evaluation of the pilot program shall be carried out measuring health outcomes and cost of care for those served by the pilot program compared to similarly situated patients who are not served by the pilot program.

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

Any medical or health care provider shall immediately recommend, to any pregnant woman who is being provided prenatal services and is suspected of having a substance use disorder as

1 defined in the Substance Use Disorder Act, referral to a local
2 substance use disorder treatment program licensed by the
3 Department of Human Services or to a licensed hospital which
4 provides substance abuse treatment services. The Department of
5 Healthcare and Family Services shall assure coverage for the
6 cost of treatment of the drug abuse or addiction for pregnant
7 recipients in accordance with the Illinois Medicaid Program in
8 conjunction with the Department of Human Services.

9 All medical providers providing medical assistance to
10 pregnant women under this Code shall receive information from
11 the Department on the availability of services under any
12 program providing case management services for addicted women,
13 including information on appropriate referrals for other
14 social services that may be needed by addicted women in
15 addition to treatment for addiction.

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

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

The Illinois Department shall establish such regulations governing the dispensing of health services under this Article as it shall deem appropriate. The Department should seek the advice of formal professional advisory committees appointed by the Director of the Illinois Department for the purpose of providing regular advice on policy and administrative matters, information dissemination and educational activities for medical and health care providers, and consistency in procedures to the Illinois Department.

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

The sponsor must negotiate formal written contracts with medical providers for physician services, inpatient and outpatient hospital care, home health services, treatment for alcoholism and substance abuse, and other services determined necessary by the Illinois Department by rule for delivery by Partnerships. Physician services must include prenatal and obstetrical care. The Illinois Department shall reimburse medical services delivered by Partnership providers to clients

in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

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

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

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

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

Nothing in this Section shall limit the free choice of practitioners, hospitals, and other providers of medical services by clients. In order to ensure patient freedom of

1 choice, the Illinois Department shall immediately promulgate
2 all rules and take all other necessary actions so that provided
3 services may be accessed from therapeutically certified
4 optometrists to the full extent of the Illinois Optometric
5 Practice Act of 1987 without discriminating between service
6 providers.

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

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

1 eligible for medical assistance under this Code, in accordance
2 with regulations promulgated by the Illinois Department. The
3 rules and regulations shall require that proof of the receipt
4 of prescription drugs, dentures, prosthetic devices and
5 eyeglasses by eligible persons under this Section accompany
6 each claim for reimbursement submitted by the dispenser of such
7 medical services. No such claims for reimbursement shall be
8 approved for payment by the Illinois Department without such
9 proof of receipt, unless the Illinois Department shall have put
10 into effect and shall be operating a system of post-payment
11 audit and review which shall, on a sampling basis, be deemed
12 adequate by the Illinois Department to assure that such drugs,
13 dentures, prosthetic devices and eyeglasses for which payment
14 is being made are actually being received by eligible
15 recipients. Within 90 days after September 16, 1984 (the
16 effective date of Public Act 83-1439), the Illinois Department
17 shall establish a current list of acquisition costs for all
18 prosthetic devices and any other items recognized as medical
19 equipment and supplies reimbursable under this Article and
20 shall update such list on a quarterly basis, except that the
21 acquisition costs of all prescription drugs shall be updated no
22 less frequently than every 30 days as required by Section
23 5-5.12.

24 Notwithstanding any other law to the contrary, the Illinois
25 Department shall, within 365 days after July 22, 2013 (the
26 effective date of Public Act 98-104), establish procedures to

1 permit skilled care facilities licensed under the Nursing Home
2 Care Act to submit monthly billing claims for reimbursement
3 purposes. Following development of these procedures, the
4 Department shall, by July 1, 2016, test the viability of the
5 new system and implement any necessary operational or
6 structural changes to its information technology platforms in
7 order to allow for the direct acceptance and payment of nursing
8 home claims.

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

19 The Illinois Department shall require all dispensers of
20 medical services, other than an individual practitioner or
21 group of practitioners, desiring to participate in the Medical
22 Assistance program established under this Article to disclose
23 all financial, beneficial, ownership, equity, surety or other
24 interests in any and all firms, corporations, partnerships,
25 associations, business enterprises, joint ventures, agencies,
26 institutions or other legal entities providing any form of

1 health care services in this State under this Article.
2 The Illinois Department may require that all dispensers of
3 medical services desiring to participate in the medical
4 assistance program established under this Article disclose,
5 under such terms and conditions as the Illinois Department may
6 by rule establish, all inquiries from clients and attorneys
7 regarding medical bills paid by the Illinois Department, which
8 inquiries could indicate potential existence of claims or liens
9 for the Illinois Department.
10 Enrollment of a vendor shall be subject to a provisional
11 period and shall be conditional for one year. During the period
12 of conditional enrollment, the Department may terminate the
13 vendor's eligibility to participate in, or may disenroll the
14 vendor from, the medical assistance program without cause.
15 Unless otherwise specified, such termination of eligibility or
16 disenrollment is not subject to the Department's hearing
17 process. However, a disenrolled vendor may reapply without
18 penalty.
19 The Department has the discretion to limit the conditional
20 enrollment period for vendors based upon category of risk of
21 the vendor.
22 Prior to enrollment and during the conditional enrollment
23 period in the medical assistance program, all vendors shall be
24 subject to enhanced oversight, screening, and review based on
25 the risk of fraud, waste, and abuse that is posed by the
26 category of risk of the vendor. The Illinois Department shall

1 establish the procedures for oversight, screening, and review,
2 which may include, but need not be limited to: criminal and
3 financial background checks; fingerprinting; license,
4 certification, and authorization verifications; unscheduled or
5 unannounced site visits; database checks; prepayment audit
6 reviews; audits; payment caps; payment suspensions; and other
7 screening as required by federal or State law.

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

18 To be eligible for payment consideration, a vendor's
19 payment claim or bill, either as an initial claim or as a
20 resubmitted claim following prior rejection, must be received
21 by the Illinois Department, or its fiscal intermediary, no
22 later than 180 days after the latest date on the claim on which
23 medical goods or services were provided, with the following
24 exceptions:

25 (1) In the case of a provider whose enrollment is in
26 process by the Illinois Department, the 180-day period

shall not begin until the date on the written notice from the Illinois Department that the provider enrollment is complete.

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

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

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

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

In the case of long term care facilities, within 45 calendar days of receipt by the facility of required prescreening information, new admissions with associated admission documents shall be submitted through the Medical Electronic Data Interchange (MEDI) or the Recipient

Eligibility Verification (REV) System or shall be submitted directly to the Department of Human Services using required admission forms. Effective September 1, 2014, admission documents, including all prescreening information, must be submitted through MEDI or REV. Confirmation numbers assigned to an accepted transaction shall be retained by a facility to verify timely submittal. Once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.

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

To the extent consistent with applicable information and privacy, security, and disclosure laws, State and federal agencies and departments shall provide the Illinois Department access to confidential and other information and data necessary to perform eligibility and payment verifications and other Illinois Department functions. This includes, but is not limited to: information pertaining to licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency

1 exclusions; taxpayer identification numbers; tax delinquency;
2 corporate information; and death records.

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

19 Beginning in fiscal year 2013, the Illinois Department
20 shall set forth a request for information to identify the
21 benefits of a pre-payment, post-adjudication, and post-edit
22 claims system with the goals of streamlining claims processing
23 and provider reimbursement, reducing the number of pending or
24 rejected claims, and helping to ensure a more transparent
25 adjudication process through the utilization of: (i) provider
26 data verification and provider screening technology; and (ii)

1 clinical code editing; and (iii) pre-pay, pre- or
2 post-adjudicated predictive modeling with an integrated case
3 management system with link analysis. Such a request for
4 information shall not be considered as a request for proposal
5 or as an obligation on the part of the Illinois Department to
6 take any action or acquire any products or services.

7 The Illinois Department shall establish policies,
8 procedures, standards and criteria by rule for the acquisition,
9 repair and replacement of orthotic and prosthetic devices and
10 durable medical equipment. Such rules shall provide, but not be
11 limited to, the following services: (1) immediate repair or
12 replacement of such devices by recipients; and (2) rental,
13 lease, purchase or lease-purchase of durable medical equipment
14 in a cost-effective manner, taking into consideration the
15 recipient's medical prognosis, the extent of the recipient's
16 needs, and the requirements and costs for maintaining such
17 equipment. Subject to prior approval, such rules shall enable a
18 recipient to temporarily acquire and use alternative or
19 substitute devices or equipment pending repairs or
20 replacements of any device or equipment previously authorized
21 for such recipient by the Department. Notwithstanding any
22 provision of Section 5-5f to the contrary, the Department may,
23 by rule, exempt certain replacement wheelchair parts from prior
24 approval and, for wheelchairs, wheelchair parts, wheelchair
25 accessories, and related seating and positioning items,
26 determine the wholesale price by methods other than actual

1 acquisition costs.
2 The Department shall require, by rule, all providers of
3 durable medical equipment to be accredited by an accreditation
4 organization approved by the federal Centers for Medicare and
5 Medicaid Services and recognized by the Department in order to
6 bill the Department for providing durable medical equipment to
7 recipients. No later than 15 months after the effective date of
8 the rule adopted pursuant to this paragraph, all providers must
9 meet the accreditation requirement.
10 In order to promote environmental responsibility, meet the
11 needs of recipients and enrollees, and achieve significant cost
12 savings, the Department, or a managed care organization under
13 contract with the Department, may provide recipients or managed
14 care enrollees who have a prescription or Certificate of
15 Medical Necessity access to refurbished durable medical
16 equipment under this Section (excluding prosthetic and
17 orthotic devices as defined in the Orthotics, Prosthetics, and
18 Pedorthics Practice Act and complex rehabilitation technology
19 products and associated services) through the State's
20 assistive technology program's reutilization program, using
21 staff with the Assistive Technology Professional (ATP)
22 Certification if the refurbished durable medical equipment:
23 (i) is available; (ii) is less expensive, including shipping
24 costs, than new durable medical equipment of the same type;
25 (iii) is able to withstand at least 3 years of use; (iv) is
26 cleaned, disinfected, sterilized, and safe in accordance with

federal Food and Drug Administration regulations and guidance governing the reprocessing of medical devices in health care settings; and (v) equally meets the needs of the recipient or enrollee. The reutilization program shall confirm that the recipient or enrollee is not already in receipt of same or similar equipment from another service provider, and that the refurbished durable medical equipment equally meets the needs of the recipient or enrollee. Nothing in this paragraph shall be construed to limit recipient or enrollee choice to obtain new durable medical equipment or place any additional prior authorization conditions on enrollees of managed care organizations.

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped; and (iii) ~~notwithstanding any other provision of law, subject to federal approval, on and after July 1, 2012, an increase in the determination of need (DON) scores from 29 to 37 for applicants for institutional and home and community-based long term care; if and only if federal approval is not granted, the Department may, in conjunction with other affected agencies, implement~~

~~utilization controls or changes in benefit packages to effectuate a similar savings amount for this population; and (iv)~~ no later than July 1, 2013, minimum level of care eligibility criteria for institutional and home and community-based long term care; and (iv) ~~(v)~~ no later than October 1, 2013, establish procedures to permit long term care providers access to eligibility scores for individuals with an admission date who are seeking or receiving services from the long term care provider. In order to select the minimum level of care eligibility criteria, the Governor shall establish a workgroup that includes affected agency representatives and stakeholders representing the institutional and home and community-based long term care interests. This Section shall not restrict the Department from implementing lower level of care eligibility criteria for community-based services in circumstances where federal approval has been granted. Individuals with a score of 29 or higher based on the determination of need (DON) assessment tool shall be eligible to receive institutional and home and community-based long term care services until the State receives federal approval and implements an updated assessment tool, and those individuals are found to be ineligible under that updated assessment tool. Anyone determined to be ineligible for services due to the updated assessment tool shall continue to be eligible for services for at least one year following that determination and must be reassessed no earlier than 11 months after that

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

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

20 The Illinois Department shall report annually to the
21 General Assembly, no later than the second Friday in April of
22 1979 and each year thereafter, in regard to:

23 (a) actual statistics and trends in utilization of
24 medical services by public aid recipients;

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

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

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

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall include suggested legislation for consideration by the General Assembly. The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act, and filing such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

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

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

Because kidney transplantation can be an appropriate, cost-effective alternative to renal dialysis when medically

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

15 Notwithstanding any other provision of this Code to the
16 contrary, on or after July 1, 2015, all FDA approved forms of
17 medication assisted treatment prescribed for the treatment of
18 alcohol dependence or treatment of opioid dependence shall be
19 covered under both fee for service and managed care medical
20 assistance programs for persons who are otherwise eligible for
21 medical assistance under this Article and shall not be subject
22 to any (1) utilization control, other than those established
23 under the American Society of Addiction Medicine patient
24 placement criteria, (2) prior authorization mandate, or (3)
25 lifetime restriction limit mandate.

26 On or after July 1, 2015, opioid antagonists prescribed for

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

12 Upon federal approval, the Department shall provide
13 coverage and reimbursement for all drugs that are approved for
14 marketing by the federal Food and Drug Administration and that
15 are recommended by the federal Public Health Service or the
16 United States Centers for Disease Control and Prevention for
17 pre-exposure prophylaxis and related pre-exposure prophylaxis
18 services, including, but not limited to, HIV and sexually
19 transmitted infection screening, treatment for sexually
20 transmitted infections, medical monitoring, assorted labs, and
21 counseling to reduce the likelihood of HIV infection among
22 individuals who are not infected with HIV but who are at high
23 risk of HIV infection.

24 A federally qualified health center, as defined in Section
25 1905(l)(2)(B) of the federal Social Security Act, shall be
26 reimbursed by the Department in accordance with the federally

qualified health center's encounter rate for services provided to medical assistance recipients that are performed by a dental hygienist, as defined under the Illinois Dental Practice Act, working under the general supervision of a dentist and employed by a federally qualified health center.

Notwithstanding any other provision of this Code, the Illinois Department shall authorize licensed dietitian nutritionists and certified diabetes educators to counsel senior diabetes patients in the senior diabetes patients' homes to remove the hurdle of transportation for senior diabetes patients to receive treatment.

(Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for the effective date of P.A. 99-407); 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201, eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff. 12-10-18.)

(305 ILCS 5/5-5.01a)

Sec. 5-5.01a. Supportive living facilities program.

(a) The Department shall establish and provide oversight for a program of supportive living facilities that seek to

1 promote resident independence, dignity, respect, and
2 well-being in the most cost-effective manner.
3 A supportive living facility is (i) a free-standing
4 facility or (ii) a distinct physical and operational entity
5 within a mixed-use building that meets the criteria established
6 in subsection (d). A supportive living facility integrates
7 housing with health, personal care, and supportive services and
8 is a designated setting that offers residents their own
9 separate, private, and distinct living units.
10 Sites for the operation of the program shall be selected by
11 the Department based upon criteria that may include the need
12 for services in a geographic area, the availability of funding,
13 and the site's ability to meet the standards.
14 (b) Beginning July 1, 2014, subject to federal approval,
15 the Medicaid rates for supportive living facilities shall be
16 equal to the supportive living facility Medicaid rate effective
17 on June 30, 2014 increased by 8.85%. Once the assessment
18 imposed at Article V-G of this Code is determined to be a
19 permissible tax under Title XIX of the Social Security Act, the
20 Department shall increase the Medicaid rates for supportive
21 living facilities effective on July 1, 2014 by 9.09%. The
22 Department shall apply this increase retroactively to coincide
23 with the imposition of the assessment in Article V-G of this
24 Code in accordance with the approval for federal financial
25 participation by the Centers for Medicare and Medicaid
26 Services.

The Medicaid rates for supportive living facilities effective on July 1, 2017 must be equal to the rates in effect for supportive living facilities on June 30, 2017 increased by 2.8%.

The Medicaid rates for supportive living facilities effective on July 1, 2018 must be equal to the rates in effect for supportive living facilities on June 30, 2018.

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

(d) Subject to federal approval by the Centers for Medicare and Medicaid Services, the Department shall accept for consideration of certification under the program any application for a site or building where distinct parts of the site or building are designated for purposes other than the provision of supportive living services, but only if:

(1) those distinct parts of the site or building are not designated for the purpose of providing assisted living services as required under the Assisted Living and Shared Housing Act;

(2) those distinct parts of the site or building are completely separate from the part of the building used for

1 the provision of supportive living program services,
2 including separate entrances;
3 (3) those distinct parts of the site or building do not
4 share any common spaces with the part of the building used
5 for the provision of supportive living program services;
6 and
7 (4) those distinct parts of the site or building do not
8 share staffing with the part of the building used for the
9 provision of supportive living program services.
10 (e) Facilities or distinct parts of facilities which are
11 selected as supportive living facilities and are in good
12 standing with the Department's rules are exempt from the
13 provisions of the Nursing Home Care Act and the Illinois Health
14 Facilities Planning Act.
15 Individuals with a score of 29 or higher based on the
16 determination of need (DON) assessment tool shall be eligible
17 to receive institutional and home and community-based long term
18 care services until the State receives federal approval and
19 implements an updated assessment tool, and those individuals
20 are found to be ineligible under that updated assessment tool.
21 Anyone determined to be ineligible for services due to the
22 updated assessment tool shall continue to be eligible for
23 services for at least one year following that determination and
24 must be reassessed no earlier than 11 months after that
25 determination. The Department must adopt rules through the
26 regular rulemaking process regarding the updated assessment

tool, and shall not adopt emergency or peremptory rules regarding the updated assessment tool. The State shall not implement an updated assessment tool that causes more than 1% of then-current recipients to lose eligibility. No individual receiving care in an institutional setting shall be involuntarily discharged as the result of the updated assessment tool until a transition plan has been developed by the Department on Aging or its designee and all care identified in the transition plan is available to the resident immediately upon discharge.

(Source: P.A. 100-23, eff. 7-6-17; 100-583, eff. 4-6-18; 100-587, eff. 6-4-18.)

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

1 INDEX

2 Statutes amended in order of appearance

3 20 ILCS 105/4.02 from Ch. 23, par. 6104.02
4 20 ILCS 2405/3 from Ch. 23, par. 3434
5 210 ILCS 45/3-402 from Ch. 111 1/2, par. 4153-402
6 305 ILCS 5/5-5 from Ch. 23, par. 5-5
7 305 ILCS 5/5-5.01a