LRB102 10090 KTG 15410 b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB0422

Introduced 2/8/2021, 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.
14 Such 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
2 need 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
10 not 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
15 term care services until the State receives federal approval
16 and implements an updated assessment tool, and those
17 individuals are found to be ineligible under that updated
18 assessment tool. Anyone determined to be ineligible for
19 services due to the updated assessment tool shall continue to
20 be eligible for services for at least one year following that
21 determination and must be reassessed no earlier than 11 months
22 after that determination. The Department must adopt rules
23 through the regular rulemaking process regarding the updated
24 assessment tool, and shall not adopt emergency or peremptory
25 rules regarding the updated assessment tool. The State shall
26 not 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
12 restricts eligibility under the Community Care Program to
13 persons who qualify for medical assistance under Article V of
14 the Illinois Public Aid Code; or (ii) establish, by rule, a
15 separate program of home and community-based long term care
16 services for persons who are otherwise eligible for services
17 under the Community Care Program but who do not qualify for
18 medical assistance under Article V of the Illinois Public Aid
19 Code.
20 The Department shall, in conjunction with the Department
21 of Public Aid (now Department of Healthcare and Family
22 Services), seek appropriate amendments under Sections 1915 and
23 1924 of the Social Security Act. The purpose of the amendments
24 shall be to extend eligibility for home and community based
25 services under Sections 1915 and 1924 of the Social Security
26 Act to persons who transfer to or for the benefit of a spouse

1 those amounts of income and resources allowed under Section
2 1924 of the Social Security Act. Subject to the approval of
3 such amendments, the Department shall extend the provisions of
4 Section 5-4 of the Illinois Public Aid Code to persons who, but
5 for the provision of home or community-based services, would
6 require the level of care provided in an institution, as is
7 provided for in federal law. Those persons no longer found to
8 be eligible for receiving noninstitutional services due to
9 changes in the eligibility criteria shall be given 45 days
10 notice prior to actual termination. Those persons receiving
11 notice of termination may contact the Department and request
12 the determination be appealed at any time during the 45 day
13 notice period. The target population identified for the
14 purposes of this Section are persons age 60 and older with an
15 identified service need. Priority shall be given to those who
16 are at imminent risk of institutionalization. The services
17 shall be provided to eligible persons age 60 and older to the
18 extent that the cost of the services together with the other
19 personal maintenance expenses of the persons are reasonably
20 related to the standards established for care in a group
21 facility appropriate to the person's condition. These
22 non-institutional services, pilot projects or experimental
23 facilities may be provided as part of or in addition to those
24 authorized by federal law or those funded and administered by
25 the Department of Human Services. The Departments of Human
26 Services, Healthcare and Family Services, Public Health,

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

24 As part of the Department on Aging's routine training of
25 case managers and case manager supervisors, the Department may
26 include information on family futures planning for persons who

1 are age 60 or older and who are caregivers of their adult
2 children with developmental disabilities. The content of the
3 training shall be at the Department's discretion.
4 The Department is authorized to establish a system of
5 recipient copayment for services provided under this Section,
6 such copayment to be based upon the recipient's ability to pay
7 but in no case to exceed the actual cost of the services
8 provided. Additionally, any portion of a person's income which
9 is equal to or less than the federal poverty standard shall not
10 be considered by the Department in determining the copayment.
11 The level of such copayment shall be adjusted whenever
12 necessary to reflect any change in the officially designated
13 federal poverty standard. The Department shall not increase
14 copayment levels to the levels that were in effect on January
15 1, 2016, except to make an adjustment for inflation.
16 The Department, or the Department's authorized
17 representative, may recover the amount of moneys expended for
18 services provided to or in behalf of a person under this
19 Section by a claim against the person's estate or against the
20 estate of the person's surviving spouse, but no recovery may
21 be had until after the death of the surviving spouse, if any,
22 and then only at such time when there is no surviving child who
23 is under age 21 or blind or who has a permanent and total
24 disability. This paragraph, however, shall not bar recovery,
25 at the death of the person, of moneys for services provided to
26 the person or in behalf of the person under this Section to

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

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

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

23 (2) ensuring that care plans contain the services that
24 eligible participants need based on the number of days in
25 a month, not limited to specific blocks of time, as
26 identified by the comprehensive assessment tool selected

1 by the Department for use statewide, not to exceed the
2 total monthly service cost maximum allowed for each
3 service; the Department shall develop administrative rules
4 to implement this item (2);
5 (3) ensuring that the participants have the right to
6 choose the services contained in their care plan and to
7 direct how those services are provided, based on
8 administrative rules established by the Department;
9 (4) ensuring that the determination of need tool is
10 accurate in determining the participants' level of need;
11 to achieve this, the Department, in conjunction with the
12 Older Adult Services Advisory Committee, shall institute a
13 study of the relationship between the Determination of
14 Need scores, level of need, service cost maximums, and the
15 development and utilization of service plans no later than
16 May 1, 2008; findings and recommendations shall be
17 presented to the Governor and the General Assembly no
18 later than January 1, 2009; recommendations shall include
19 all needed changes to the service cost maximums schedule
20 and additional covered services;
21 (5) ensuring that homemakers can provide personal care
22 services that may or may not involve contact with clients,
23 including but not limited to:
24 (A) bathing;
25 (B) grooming;
26 (C) toileting;

1 (D) nail care;
2 (E) transferring;
3 (F) respiratory services;
4 (G) exercise; or
5 (H) positioning;
6 (6) ensuring that homemaker program vendors are not
7 restricted from hiring homemakers who are family members
8 of clients or recommended by clients; the Department may
9 not, by rule or policy, require homemakers who are family
10 members of clients or recommended by clients to accept
11 assignments in homes other than the client;
12 (7) ensuring that the State may access maximum federal
13 matching funds by seeking approval for the Centers for
14 Medicare and Medicaid Services for modifications to the
15 State's home and community based services waiver and
16 additional waiver opportunities, including applying for
17 enrollment in the Balance Incentive Payment Program by May
18 1, 2013, in order to maximize federal matching funds; this
19 shall include, but not be limited to, modification that
20 reflects all changes in the Community Care Program
21 services and all increases in the services cost maximum;
22 (8) ensuring that the determination of need tool
23 accurately reflects the service needs of individuals with
24 Alzheimer's disease and related dementia disorders;
25 (9) ensuring that services are authorized accurately
26 and consistently for the Community Care Program (CCP); the

1 Department shall implement a Service Authorization policy
2 directive; the purpose shall be to ensure that eligibility
3 and services are authorized accurately and consistently in
4 the CCP program; the policy directive shall clarify
5 service authorization guidelines to Care Coordination
6 Units and Community Care Program providers no later than
7 May 1, 2013;
8 (10) working in conjunction with Care Coordination
9 Units, the Department of Healthcare and Family Services,
10 the Department of Human Services, Community Care Program
11 providers, and other stakeholders to make improvements to
12 the Medicaid claiming processes and the Medicaid
13 enrollment procedures or requirements as needed,
14 including, but not limited to, specific policy changes or
15 rules to improve the up-front enrollment of participants
16 in the Medicaid program and specific policy changes or
17 rules to insure more prompt submission of bills to the
18 federal government to secure maximum federal matching
19 dollars as promptly as possible; the Department on Aging
20 shall have at least 3 meetings with stakeholders by
21 January 1, 2014 in order to address these improvements;
22 (11) requiring home care service providers to comply
23 with the rounding of hours worked provisions under the
24 federal Fair Labor Standards Act (FLSA) and as set forth
25 in 29 CFR 785.48(b) by May 1, 2013;
26 (12) implementing any necessary policy changes or

promulgating any rules, no later than January 1, 2014, to assist the Department of Healthcare and Family Services in 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 effect such certification shall include (i) the person's name, (ii) the date the person was hired by his or her current employer, and (iii) the training, including dates and levels. Persons engaged in the program authorized by this Section before the effective date of this amendatory Act of 1991 shall be issued a certificate of all pre- and in-service training from his or her employer upon submitting the necessary information. The employing agency shall be required to retain records of all staff pre- and in-service training, and shall provide such records to the Department upon request and upon termination of the employer's contract with the Department. In addition, the employing agency is responsible for the issuance of certifications of in-service training completed to their employees.

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

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

1 organizational entities, providers of care, or individuals
2 with demonstrated interest and expertise in the field of home
3 and community care as determined by the Director.
4 Nominations may be presented from any agency or State
5 association with interest in the program. The Director, or his
6 or her designee, shall serve as the permanent co-chair of the
7 advisory committee. One other co-chair shall be nominated and
8 approved by the members of the committee on an annual basis.
9 Committee members' terms of appointment shall be for 4 years
10 with one-quarter of the appointees' terms expiring each year.
11 A member shall continue to serve until his or her replacement
12 is named. The Department shall fill vacancies that have a
13 remaining term of over one year, and this replacement shall
14 occur through the annual replacement of expiring terms. The
15 Director shall designate Department staff to provide technical
16 assistance and staff support to the committee. Department
17 representation shall not constitute membership of the
18 committee. All Committee papers, issues, recommendations,
19 reports, and meeting memoranda are advisory only. The
20 Director, or his or her designee, shall make a written report,
21 as requested by the Committee, regarding issues before the
22 Committee.
23 The Department on Aging and the Department of Human
24 Services shall cooperate in the development and submission of
25 an annual report on programs and services provided under this
26 Section. Such joint report shall be filed with the Governor

1 and the General Assembly on or before September 30 each year.
2 The requirement for reporting to the General Assembly
3 shall be satisfied by filing copies of the report as required
4 by Section 3.1 of the General Assembly Organization Act and
5 filing such additional copies with the State Government Report
6 Distribution Center for the General Assembly as is required
7 under paragraph (t) of Section 7 of the State Library Act.
8 Those persons previously found eligible for receiving
9 non-institutional services whose services were discontinued
10 under the Emergency Budget Act of Fiscal Year 1992, and who do
11 not meet the eligibility standards in effect on or after July
12 1, 1992, shall remain ineligible on and after July 1, 1992.
13 Those persons previously not required to cost-share and who
14 were required to cost-share effective March 1, 1992, shall
15 continue to meet cost-share requirements on and after July 1,
16 1992. Beginning July 1, 1992, all clients will be required to
17 meet eligibility, cost-share, and other requirements and will
18 have services discontinued or altered when they fail to meet
19 these requirements.
20 For the purposes of this Section, "flexible senior
21 services" refers to services that require one-time or periodic
22 expenditures including, but not limited to, respite care, home
23 modification, assistive technology, housing assistance, and
24 transportation.
25 The Department shall implement an electronic service
26 verification based on global positioning systems or other

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

~~The Department shall require, as a condition of 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.

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

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

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

1 The General Assembly finds it necessary to authorize an
2 aggressive Medicaid enrollment initiative designed to maximize
3 federal Medicaid funding for the Community Care Program which
4 produces significant savings for the State of Illinois. The
5 Department on Aging shall establish and implement a Community
6 Care Program Medicaid Initiative. Under the Initiative, the
7 Department on Aging shall, at a minimum: (i) provide an
8 enhanced rate to adequately compensate care coordination units
9 to enroll eligible Community Care Program clients into
10 Medicaid; (ii) use recommendations from a stakeholder
11 committee on how best to implement the Initiative; and (iii)
12 establish requirements for State agencies to make enrollment
13 in the State's Medical Assistance program easier for seniors.

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

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

25 (2) One representative of the Department of Healthcare
26 and Family Services, appointed by the Director of

Healthcare and Family Services.

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

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

(5) One individual from a non-governmental statewide organization that advocates for seniors, appointed by the Director of Aging.

(6) One individual representing Area Agencies on Aging, appointed by the Director of Aging.

(7) One individual from a statewide association dedicated to Alzheimer's care, support, and research, appointed by the Director of Aging.

(8) One individual from an organization that employs persons who provide services under the Community Care Program, appointed by the Director of Aging.

(9) One member of a trade or labor union representing persons who provide services under the Community Care Program, appointed by the Director of Aging.

(10) One member of the Senate, who shall serve as co-chairperson, appointed by the President of the Senate.

(11) One member of the Senate, who shall serve as co-chairperson, appointed by the Minority Leader of the Senate.

(12) One member of the House of Representatives, who shall serve as co-chairperson, appointed by the Speaker of

1 the House of Representatives.
2 (13) One member of the House of Representatives, who
3 shall serve as co-chairperson, appointed by the Minority
4 Leader of the House of Representatives.
5 (14) One individual appointed by a labor organization
6 representing frontline employees at the Department of
7 Human Services.
8 The Subcommittee shall provide oversight to the Community
9 Care Program Medicaid Initiative and shall meet quarterly. At
10 each Subcommittee meeting the Department on Aging shall
11 provide the following data sets to the Subcommittee: (A) the
12 number of Illinois residents, categorized by planning and
13 service area, who are receiving services under the Community
14 Care Program and are enrolled in the State's Medical
15 Assistance Program; (B) the number of Illinois residents,
16 categorized by planning and service area, who are receiving
17 services under the Community Care Program, but are not
18 enrolled in the State's Medical Assistance Program; and (C)
19 the number of Illinois residents, categorized by planning and
20 service area, who are receiving services under the Community
21 Care Program and are eligible for benefits under the State's
22 Medical Assistance Program, but are not enrolled in the
23 State's Medical Assistance Program. In addition to this data,
24 the Department on Aging shall provide the Subcommittee with
25 plans on how the Department on Aging will reduce the number of
26 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 provided to the Subcommittee shall be made available to the public via the Department on Aging's website.

The Department on Aging, with the involvement of the Subcommittee, shall collaborate with the Department of Human Services and the Department of Healthcare and Family Services on how best to achieve the responsibilities of the Community Care Program Medicaid Initiative.

The Department on Aging, the Department of Human Services, and the Department of Healthcare and Family Services shall coordinate and implement a streamlined process for seniors to access benefits under the State's Medical Assistance Program.

The Subcommittee shall collaborate with the Department of Human Services on the adoption of a uniform application submission process. The Department of Human Services and any other State agency involved with processing the medical assistance application of any person enrolled in the Community Care Program shall include the appropriate care coordination unit in all communications related to the determination or status of the application.

The Community Care Program Medicaid Initiative shall

1 provide targeted funding to care coordination units to help
2 seniors complete their applications for medical assistance
3 benefits. On and after July 1, 2019, care coordination units
4 shall receive no less than $200 per completed application,
5 which rate may be included in a bundled rate for initial intake
6 services when Medicaid application assistance is provided in
7 conjunction with the initial intake process for new program
8 participants.

9 The Community Care Program Medicaid Initiative shall cease
10 operation 5 years after the effective date of this amendatory
11 Act of the 100th General Assembly, after which the
12 Subcommittee shall dissolve.

13 (Source: P.A. 100-23, eff. 7-6-17; 100-587, eff. 6-4-18;
14 100-1148, eff. 12-10-18; 101-10, eff. 6-5-19.)

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

17 (20 ILCS 2405/3) (from Ch. 23, par. 3434)

18 Sec. 3. Powers and duties. The Department shall have the
19 powers and duties enumerated herein:

20 (a) To co-operate with the federal government in the
21 administration of the provisions of the federal
22 Rehabilitation Act of 1973, as amended, of the Workforce
23 Innovation and Opportunity Act, and of the federal Social
24 Security Act to the extent and in the manner provided in

these Acts.

(b) To prescribe and supervise such courses of vocational training and provide such other services as may be necessary for the habilitation and rehabilitation of persons with one or more disabilities, including the administrative activities under subsection (e) of this Section, and to co-operate with State and local school authorities and other recognized agencies engaged in habilitation, rehabilitation and comprehensive rehabilitation services; and to cooperate with the Department of Children and Family Services regarding the care and education of children with one or more disabilities.

(c) (Blank).

(d) To report in writing, to the Governor, annually on or before the first day of December, and at such other times and in such manner and upon such subjects as the Governor may require. The annual report shall contain (1) a statement of the existing condition of comprehensive rehabilitation services, habilitation and rehabilitation in the State; (2) a statement of suggestions and recommendations with reference to the development of comprehensive rehabilitation services, habilitation and rehabilitation in the State; and (3) an itemized statement of the amounts of money received from federal, State and other sources, and of the objects and purposes to which

the respective items of these several amounts have been devoted.

(e) (Blank).

(f) To establish a program of services to prevent the unnecessary institutionalization of persons in need of long term care and who meet the criteria for blindness or disability as defined by the Social Security Act, thereby enabling them to remain in their own homes. Such preventive services include any or all of the following:

(1) personal assistant services;

(2) homemaker services;

(3) home-delivered meals;

(4) adult day care services;

(5) respite care;

(6) home modification or assistive equipment;

(7) home health services;

(8) electronic home response;

(9) brain injury behavioral/cognitive services;

(10) brain injury habilitation;

(11) brain injury pre-vocational services; or

(12) brain injury supported employment.

The Department shall establish eligibility standards for such services taking into consideration the unique economic and social needs of the population for whom they are to be provided. Such eligibility standards may be based on the recipient's ability to pay for services;

1 provided, however, that any portion of a person's income
2 that is equal to or less than the "protected income" level
3 shall not be considered by the Department in determining
4 eligibility. The "protected income" level shall be
5 determined by the Department, shall never be less than the
6 federal poverty standard, and shall be adjusted each year
7 to reflect changes in the Consumer Price Index For All
8 Urban Consumers as determined by the United States
9 Department of Labor. The standards must provide that a
10 person may not have more than $10,000 in assets to be
11 eligible for the services, and the Department may increase
12 or decrease the asset limitation by rule. The Department
13 may not decrease the asset level below $10,000.

14 Individuals with a score of 29 or higher based on the
15 determination of need (DON) assessment tool shall be eligible
16 to receive institutional and home and community-based long
17 term care services until the State receives federal approval
18 and implements an updated assessment tool, and those
19 individuals are found to be ineligible under that updated
20 assessment tool. Anyone determined to be ineligible for
21 services due to the updated assessment tool shall continue to
22 be eligible for services for at least one year following that
23 determination and must be reassessed no earlier than 11 months
24 after that determination. The Department must adopt rules
25 through the regular rulemaking process regarding the updated
26 assessment tool, and shall not adopt emergency or peremptory

1 rules regarding the updated assessment tool. The State shall
2 not implement an updated assessment tool that causes more than
3 1% of then-current recipients to lose eligibility.
4 Service cost maximums shall be set at levels no lower than
5 the service cost maximums that were in effect as of January 1,
6 2016. Service cost maximums shall be increased accordingly to
7 reflect any rate increases.
8 The services shall be provided, as established by the
9 Department by rule, to eligible persons to prevent
10 unnecessary or premature institutionalization, to the
11 extent that the cost of the services, together with the
12 other personal maintenance expenses of the persons, are
13 reasonably related to the standards established for care
14 in a group facility appropriate to their condition. These
15 non-institutional services, pilot projects or experimental
16 facilities may be provided as part of or in addition to
17 those authorized by federal law or those funded and
18 administered by the Illinois Department on Aging. The
19 Department shall set rates and fees for services in a fair
20 and equitable manner. Services identical to those offered
21 by the Department on Aging shall be paid at the same rate.
22 Except as otherwise provided in this paragraph,
23 personal assistants shall be paid at a rate negotiated
24 between the State and an exclusive representative of
25 personal assistants under a collective bargaining
26 agreement. In no case shall the Department pay personal

assistants an hourly wage that is less than the federal minimum wage. Within 30 days after July 6, 2017 (the effective date of Public Act 100-23), the hourly wage paid to personal assistants and individual maintenance home health workers shall be increased by $0.48 per hour.

Solely for the purposes of coverage under the Illinois Public Labor Relations Act, personal assistants providing services under the Department's Home Services Program shall be considered to be public employees and the State of Illinois shall be considered to be their employer as of July 16, 2003 (the effective date of Public Act 93-204), but not before. Solely for the purposes of coverage under the Illinois Public Labor Relations Act, home care and home health workers who function as personal assistants and individual maintenance home health workers and who also provide services under the Department's Home Services Program shall be considered to be public employees, no matter whether the State provides such services through direct fee-for-service arrangements, with the assistance of a managed care organization or other intermediary, or otherwise, and the State of Illinois shall be considered to be the employer of those persons as of January 29, 2013 (the effective date of Public Act 97-1158), but not before except as otherwise provided under this subsection (f). The State shall engage in collective bargaining with an exclusive representative of home care and home health

1 workers who function as personal assistants and individual
2 maintenance home health workers working under the Home
3 Services Program concerning their terms and conditions of
4 employment that are within the State's control. Nothing in
5 this paragraph shall be understood to limit the right of
6 the persons receiving services defined in this Section to
7 hire and fire home care and home health workers who
8 function as personal assistants and individual maintenance
9 home health workers working under the Home Services
10 Program or to supervise them within the limitations set by
11 the Home Services Program. The State shall not be
12 considered to be the employer of home care and home health
13 workers who function as personal assistants and individual
14 maintenance home health workers working under the Home
15 Services Program for any purposes not specifically
16 provided in Public Act 93-204 or Public Act 97-1158,
17 including but not limited to, purposes of vicarious
18 liability in tort and purposes of statutory retirement or
19 health insurance benefits. Home care and home health
20 workers who function as personal assistants and individual
21 maintenance home health workers and who also provide
22 services under the Department's Home Services Program
23 shall not be covered by the State Employees Group
24 Insurance Act of 1971.

25 The Department shall execute, relative to nursing home
26 prescreening, as authorized by Section 4.03 of the

1 Illinois Act on the Aging, written inter-agency agreements
2 with the Department on Aging and the Department of
3 Healthcare and Family Services, to effect the intake
4 procedures and eligibility criteria for those persons who
5 may need long term care. On and after July 1, 1996, all
6 nursing home prescreenings for individuals 18 through 59
7 years of age shall be conducted by the Department, or a
8 designee of the Department.

9 The Department is authorized to establish a system of
10 recipient cost-sharing for services provided under this
11 Section. The cost-sharing shall be based upon the
12 recipient's ability to pay for services, but in no case
13 shall the recipient's share exceed the actual cost of the
14 services provided. Protected income shall not be
15 considered by the Department in its determination of the
16 recipient's ability to pay a share of the cost of
17 services. The level of cost-sharing shall be adjusted each
18 year to reflect changes in the "protected income" level.
19 The Department shall deduct from the recipient's share of
20 the cost of services any money expended by the recipient
21 for disability-related expenses.

22 To the extent permitted under the federal Social
23 Security Act, the Department, or the Department's
24 authorized representative, may recover the amount of
25 moneys expended for services provided to or in behalf of a
26 person under this Section by a claim against the person's

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

1 regulations of the Department of Healthcare and Family
2 Services, regardless of the value of the property.
3 The Department shall submit an annual report on
4 programs and services provided under this Section. The
5 report shall be filed with the Governor and the General
6 Assembly on or before March 30 each year.
7 The requirement for reporting to the General Assembly
8 shall be satisfied by filing copies of the report as
9 required by Section 3.1 of the General Assembly
10 Organization Act, and filing additional copies with the
11 State Government Report Distribution Center for the
12 General Assembly as required under paragraph (t) of
13 Section 7 of the State Library Act.
14 (g) To establish such subdivisions of the Department
15 as shall be desirable and assign to the various
16 subdivisions the responsibilities and duties placed upon
17 the Department by law.
18 (h) To cooperate and enter into any necessary
19 agreements with the Department of Employment Security for
20 the provision of job placement and job referral services
21 to clients of the Department, including job service
22 registration of such clients with Illinois Employment
23 Security offices and making job listings maintained by the
24 Department of Employment Security available to such
25 clients.
26 (i) To possess all powers reasonable and necessary for

1 the exercise and administration of the powers, duties and
2 responsibilities of the Department which are provided for
3 by law.
4 (j) (Blank).
5 (k) (Blank).
6 (l) To establish, operate, and maintain a Statewide
7 Housing Clearinghouse of information on available
8 government subsidized housing accessible to persons with
9 disabilities and available privately owned housing
10 accessible to persons with disabilities. The information
11 shall include, but not be limited to, the location, rental
12 requirements, access features and proximity to public
13 transportation of available housing. The Clearinghouse
14 shall consist of at least a computerized database for the
15 storage and retrieval of information and a separate or
16 shared toll free telephone number for use by those seeking
17 information from the Clearinghouse. Department offices and
18 personnel throughout the State shall also assist in the
19 operation of the Statewide Housing Clearinghouse.
20 Cooperation with local, State, and federal housing
21 managers shall be sought and extended in order to
22 frequently and promptly update the Clearinghouse's
23 information.
24 (m) To assure that the names and case records of
25 persons who received or are receiving services from the
26 Department, including persons receiving vocational

1 rehabilitation, home services, or other services, and
2 those attending one of the Department's schools or other
3 supervised facility shall be confidential and not be open
4 to the general public. Those case records and reports or
5 the information contained in those records and reports
6 shall be disclosed by the Director only to proper law
7 enforcement officials, individuals authorized by a court,
8 the General Assembly or any committee or commission of the
9 General Assembly, and other persons and for reasons as the
10 Director designates by rule. Disclosure by the Director
11 may be only in accordance with other applicable law.
12 (Source: P.A. 99-143, eff. 7-27-15; 100-23, eff. 7-6-17;
13 100-477, eff. 9-8-17; 100-587, eff. 6-4-18; 100-863, eff.
14 8-14-18; 100-1148, eff. 12-10-18.)

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

17 (210 ILCS 45/3-402) (from Ch. 111 1/2, par. 4153-402)
18 Sec. 3-402. Involuntary transfer or discharge.
19 Involuntary transfer or discharge of a resident from a
20 facility shall be preceded by the discussion required under
21 Section 3-408 and by a minimum written notice of 21 days,
22 except in one of the following instances:
23 (a) When an emergency transfer or discharge is ordered
24 by the resident's attending physician because of the

1 resident's health care needs.
2 (b) When the transfer or discharge is mandated by the
3 physical safety of other residents, the facility staff, or
4 facility visitors, as documented in the clinical record.
5 The Department shall be notified prior to any such
6 involuntary transfer or discharge. The Department shall
7 immediately offer transfer, or discharge and relocation
8 assistance to residents transferred or discharged under
9 this subparagraph (b), and the Department may place
10 relocation teams as provided in Section 3-419 of this Act.
11 (c) When an identified offender is within the
12 provisional admission period defined in Section 1-120.3.
13 If the Identified Offender Report and Recommendation
14 prepared under Section 2-201.6 shows that the identified
15 offender poses a serious threat or danger to the physical
16 safety of other residents, the facility staff, or facility
17 visitors in the admitting facility and the facility
18 determines that it is unable to provide a safe environment
19 for the other residents, the facility staff, or facility
20 visitors, the facility shall transfer or discharge the
21 identified offender within 3 days after its receipt of the
22 Identified Offender Report and Recommendation.
23 No individual receiving care in an institutional setting
24 shall be involuntarily discharged as the result of the updated
25 determination of need (DON) assessment tool as provided in
26 Section 5-5 of the Illinois Public Aid Code until a transition

1 plan has been developed by the Department on Aging or its
2 designee and all care identified in the transition plan is
3 available to the resident immediately upon discharge.
4 (Source: P.A. 96-1372, eff. 7-29-10.)

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

7 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)
8 Sec. 5-5. Medical services. The Illinois Department, by
9 rule, shall determine the quantity and quality of and the rate
10 of reimbursement for the medical assistance for which payment
11 will be authorized, and the medical services to be provided,
12 which may include all or part of the following: (1) inpatient
13 hospital services; (2) outpatient hospital services; (3) other
14 laboratory and X-ray services; (4) skilled nursing home
15 services; (5) physicians' services whether furnished in the
16 office, the patient's home, a hospital, a skilled nursing
17 home, or elsewhere; (6) medical care, or any other type of
18 remedial care furnished by licensed practitioners; (7) home
19 health care services; (8) private duty nursing service; (9)
20 clinic services; (10) dental services, including prevention
21 and treatment of periodontal disease and dental caries disease
22 for pregnant women, provided by an individual licensed to
23 practice dentistry or dental surgery; for purposes of this
24 item (10), "dental services" means diagnostic, preventive, or

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

1 laws of this State. The term "any other type of remedial care"
2 shall include nursing care and nursing home service for
3 persons who rely on treatment by spiritual means alone through
4 prayer for healing.

5 Notwithstanding any other provision of this Section, a
6 comprehensive tobacco use cessation program that includes
7 purchasing prescription drugs or prescription medical devices
8 approved by the Food and Drug Administration shall be covered
9 under the medical assistance program under this Article for
10 persons who are otherwise eligible for assistance under this
11 Article.

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

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

24 Upon receipt of federal approval of an amendment to the
25 Illinois Title XIX State Plan for this purpose, the Department
26 shall authorize the Chicago Public Schools (CPS) to procure a

1 vendor or vendors to manufacture eyeglasses for individuals
2 enrolled in a school within the CPS system. CPS shall ensure
3 that its vendor or vendors are enrolled as providers in the
4 medical assistance program and in any capitated Medicaid
5 managed care entity (MCE) serving individuals enrolled in a
6 school within the CPS system. Under any contract procured
7 under this provision, the vendor or vendors must serve only
8 individuals enrolled in a school within the CPS system. Claims
9 for services provided by CPS's vendor or vendors to recipients
10 of benefits in the medical assistance program under this Code,
11 the Children's Health Insurance Program, or the Covering ALL
12 KIDS Health Insurance Program shall be submitted to the
13 Department or the MCE in which the individual is enrolled for
14 payment and shall be reimbursed at the Department's or the
15 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

1 On and after July 1, 2018, the Department of Healthcare
2 and Family Services shall provide dental services to any adult
3 who is otherwise eligible for assistance under the medical
4 assistance program. As used in this paragraph, "dental
5 services" means diagnostic, preventative, restorative, or
6 corrective procedures, including procedures and services for
7 the prevention and treatment of periodontal disease and dental
8 caries disease, provided by an individual who is licensed to
9 practice dentistry or dental surgery or who is under the
10 supervision of a dentist in the practice of his or her
11 profession.
12 On and after July 1, 2018, targeted dental services, as
13 set forth in Exhibit D of the Consent Decree entered by the
14 United States District Court for the Northern District of
15 Illinois, Eastern Division, in the matter of Memisovski v.
16 Maram, Case No. 92 C 1982, that are provided to adults under
17 the medical assistance program shall be established at no less
18 than the rates set forth in the "New Rate" column in Exhibit D
19 of the Consent Decree for targeted dental services that are
20 provided to persons under the age of 18 under the medical
21 assistance program.
22 Notwithstanding any other provision of this Code and
23 subject to federal approval, the Department may adopt rules to
24 allow a dentist who is volunteering his or her service at no
25 cost to render dental services through an enrolled
26 not-for-profit health clinic without the dentist personally

1 enrolling as a participating provider in the medical
2 assistance program. A not-for-profit health clinic shall
3 include a public health clinic or Federally Qualified Health
4 Center or other enrolled provider, as determined by the
5 Department, through which dental services covered under this
6 Section are performed. The Department shall establish a
7 process for payment of claims for reimbursement for covered
8 dental services rendered under this provision.

9 The Illinois Department, by rule, may distinguish and
10 classify the medical services to be provided only in
11 accordance with the classes of persons designated in Section
12 5-2.

13 The Department of Healthcare and Family Services must
14 provide coverage and reimbursement for amino acid-based
15 elemental formulas, regardless of delivery method, for the
16 diagnosis and treatment of (i) eosinophilic disorders and (ii)
17 short bowel syndrome when the prescribing physician has issued
18 a written order stating that the amino acid-based elemental
19 formula is medically necessary.

20 The Illinois Department shall authorize the provision of,
21 and shall authorize payment for, screening by low-dose
22 mammography for the presence of occult breast cancer for women
23 35 years of age or older who are eligible for medical
24 assistance under this Article, as follows:

25 (A) A baseline mammogram for women 35 to 39 years of
26 age.

1 (B) An annual mammogram for women 40 years of age or
2 older.
3 (C) A mammogram at the age and intervals considered
4 medically necessary by the woman's health care provider
5 for women under 40 years of age and having a family history
6 of breast cancer, prior personal history of breast cancer,
7 positive genetic testing, or other risk factors.
8 (D) A comprehensive ultrasound screening and MRI of an
9 entire breast or breasts if a mammogram demonstrates
10 heterogeneous or dense breast tissue or when medically
11 necessary as determined by a physician licensed to
12 practice medicine in all of its branches.
13 (E) A screening MRI when medically necessary, as
14 determined by a physician licensed to practice medicine in
15 all of its branches.
16 (F) A diagnostic mammogram when medically necessary,
17 as determined by a physician licensed to practice medicine
18 in all its branches, advanced practice registered nurse,
19 or physician assistant.
20 The Department shall not impose a deductible, coinsurance,
21 copayment, or any other cost-sharing requirement on the
22 coverage provided under this paragraph; except that this
23 sentence does not apply to coverage of diagnostic mammograms
24 to the extent such coverage would disqualify a high-deductible
25 health plan from eligibility for a health savings account
26 pursuant to Section 223 of the Internal Revenue Code (26

1 U.S.C. 223).

2 All screenings shall include a physical breast exam,
3 instruction on self-examination and information regarding the
4 frequency of self-examination and its value as a preventative
5 tool.

6 For purposes of this Section:

7 "Diagnostic mammogram" means a mammogram obtained using
8 diagnostic mammography.

9 "Diagnostic mammography" means a method of screening that
10 is designed to evaluate an abnormality in a breast, including
11 an abnormality seen or suspected on a screening mammogram or a
12 subjective or objective abnormality otherwise detected in the
13 breast.

14 "Low-dose mammography" means the x-ray examination of the
15 breast using equipment dedicated specifically for mammography,
16 including the x-ray tube, filter, compression device, and
17 image receptor, with an average radiation exposure delivery of
18 less than one rad per breast for 2 views of an average size
19 breast. The term also includes digital mammography and
20 includes breast tomosynthesis.

21 "Breast tomosynthesis" means a radiologic procedure that
22 involves the acquisition of projection images over the
23 stationary breast to produce cross-sectional digital
24 three-dimensional images of the breast.

25 If, at any time, the Secretary of the United States
26 Department of Health and Human Services, or its successor

1 agency, promulgates rules or regulations to be published in
2 the Federal Register or publishes a comment in the Federal
3 Register or issues an opinion, guidance, or other action that
4 would require the State, pursuant to any provision of the
5 Patient Protection and Affordable Care Act (Public Law
6 111-148), including, but not limited to, 42 U.S.C.
7 18031(d)(3)(B) or any successor provision, to defray the cost
8 of any coverage for breast tomosynthesis outlined in this
9 paragraph, then the requirement that an insurer cover breast
10 tomosynthesis is inoperative other than any such coverage
11 authorized under Section 1902 of the Social Security Act, 42
12 U.S.C. 1396a, and the State shall not assume any obligation
13 for the cost of coverage for breast tomosynthesis set forth in
14 this paragraph.

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

20 On and after January 1, 2012, providers participating in a
21 quality improvement program approved by the Department shall
22 be reimbursed for screening and diagnostic mammography at the
23 same rate as the Medicare program's rates, including the
24 increased reimbursement for digital mammography.

25 The Department shall convene an expert panel including
26 representatives of hospitals, free-standing mammography

1 facilities, and doctors, including radiologists, to establish
2 quality standards for mammography.
3 On and after January 1, 2017, providers participating in a
4 breast cancer treatment quality improvement program approved
5 by the Department shall be reimbursed for breast cancer
6 treatment at a rate that is no lower than 95% of the Medicare
7 program's rates for the data elements included in the breast
8 cancer treatment quality program.
9 The Department shall convene an expert panel, including
10 representatives of hospitals, free-standing breast cancer
11 treatment centers, breast cancer quality organizations, and
12 doctors, including breast surgeons, reconstructive breast
13 surgeons, oncologists, and primary care providers to establish
14 quality standards for breast cancer treatment.
15 Subject to federal approval, the Department shall
16 establish a rate methodology for mammography at federally
17 qualified health centers and other encounter-rate clinics.
18 These clinics or centers may also collaborate with other
19 hospital-based mammography facilities. By January 1, 2016, the
20 Department shall report to the General Assembly on the status
21 of the provision set forth in this paragraph.
22 The Department shall establish a methodology to remind
23 women who are age-appropriate for screening mammography, but
24 who have not received a mammogram within the previous 18
25 months, of the importance and benefit of screening
26 mammography. The Department shall work with experts in breast

1 cancer outreach and patient navigation to optimize these
2 reminders and shall establish a methodology for evaluating
3 their effectiveness and modifying the methodology based on the
4 evaluation.

5 The Department shall establish a performance goal for
6 primary care providers with respect to their female patients
7 over age 40 receiving an annual mammogram. This performance
8 goal shall be used to provide additional reimbursement in the
9 form of a quality performance bonus to primary care providers
10 who meet that goal.

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

25 The Department shall require all networks of care to
26 develop a means either internally or by contract with experts

1 in navigation and community outreach to navigate cancer
2 patients to comprehensive care in a timely fashion. The
3 Department shall require all networks of care to include
4 access for patients diagnosed with cancer to at least one
5 academic commission on cancer-accredited cancer program as an
6 in-network covered benefit.

7 Any medical or health care provider shall immediately
8 recommend, to any pregnant woman who is being provided
9 prenatal services and is suspected of having a substance use
10 disorder as defined in the Substance Use Disorder Act,
11 referral to a local substance use disorder treatment program
12 licensed by the Department of Human Services or to a licensed
13 hospital which provides substance abuse treatment services.
14 The Department of Healthcare and Family Services shall assure
15 coverage for the cost of treatment of the drug abuse or
16 addiction for pregnant recipients in accordance with the
17 Illinois Medicaid Program in conjunction with the Department
18 of Human Services.

19 All medical providers providing medical assistance to
20 pregnant women under this Code shall receive information from
21 the Department on the availability of services under any
22 program providing case management services for addicted women,
23 including information on appropriate referrals for other
24 social services that may be needed by addicted women in
25 addition to treatment for addiction.

26 The Illinois Department, in cooperation with the

1 Departments of Human Services (as successor to the Department
2 of Alcoholism and Substance Abuse) and Public Health, through
3 a public awareness campaign, may provide information
4 concerning treatment for alcoholism and drug abuse and
5 addiction, prenatal health care, and other pertinent programs
6 directed at reducing the number of drug-affected infants born
7 to recipients of medical assistance.

8 Neither the Department of Healthcare and Family Services
9 nor the Department of Human Services shall sanction the
10 recipient solely on the basis of her substance abuse.

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

20 The Illinois Department may develop and contract with
21 Partnerships of medical providers to arrange medical services
22 for persons eligible under Section 5-2 of this Code.
23 Implementation of this Section may be by demonstration
24 projects in certain geographic areas. The Partnership shall be
25 represented by a sponsor organization. The Department, by
26 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

1 qualifications to participate in Partnerships to ensure the
2 delivery of high quality medical services. These
3 qualifications shall be determined by rule of the Illinois
4 Department and may be higher than qualifications for
5 participation in the medical assistance program. Partnership
6 sponsors may prescribe reasonable additional qualifications
7 for participation by medical providers, only with the prior
8 written approval of the Illinois Department.

9 Nothing in this Section shall limit the free choice of
10 practitioners, hospitals, and other providers of medical
11 services by clients. In order to ensure patient freedom of
12 choice, the Illinois Department shall immediately promulgate
13 all rules and take all other necessary actions so that
14 provided services may be accessed from therapeutically
15 certified optometrists to the full extent of the Illinois
16 Optometric Practice Act of 1987 without discriminating between
17 service providers.

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

21 The Illinois Department shall require health care
22 providers to maintain records that document the medical care
23 and services provided to recipients of Medical Assistance
24 under this Article. Such records must be retained for a period
25 of not less than 6 years from the date of service or as
26 provided by applicable State law, whichever period is longer,

1 except that if an audit is initiated within the required
2 retention period then the records must be retained until the
3 audit is completed and every exception is resolved. The
4 Illinois Department shall require health care providers to
5 make available, when authorized by the patient, in writing,
6 the medical records in a timely fashion to other health care
7 providers who are treating or serving persons eligible for
8 Medical Assistance under this Article. All dispensers of
9 medical services shall be required to maintain and retain
10 business and professional records sufficient to fully and
11 accurately document the nature, scope, details and receipt of
12 the health care provided to persons eligible for medical
13 assistance under this Code, in accordance with regulations
14 promulgated by the Illinois Department. The rules and
15 regulations shall require that proof of the receipt of
16 prescription drugs, dentures, prosthetic devices and
17 eyeglasses by eligible persons under this Section accompany
18 each claim for reimbursement submitted by the dispenser of
19 such medical services. No such claims for reimbursement shall
20 be approved for payment by the Illinois Department without
21 such proof of receipt, unless the Illinois Department shall
22 have put into effect and shall be operating a system of
23 post-payment audit and review which shall, on a sampling
24 basis, be deemed adequate by the Illinois Department to assure
25 that such drugs, dentures, prosthetic devices and eyeglasses
26 for which payment is being made are actually being received by

1 eligible recipients. Within 90 days after September 16, 1984
2 (the effective date of Public Act 83-1439), the Illinois
3 Department shall establish a current list of acquisition costs
4 for all prosthetic devices and any other items recognized as
5 medical equipment and supplies reimbursable under this Article
6 and shall update such list on a quarterly basis, except that
7 the acquisition costs of all prescription drugs shall be
8 updated no less frequently than every 30 days as required by
9 Section 5-5.12.

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

21 Notwithstanding any other law to the contrary, the
22 Illinois Department shall, within 365 days after August 15,
23 2014 (the effective date of Public Act 98-963), establish
24 procedures to permit ID/DD facilities licensed under the ID/DD
25 Community Care Act and MC/DD facilities licensed under the
26 MC/DD Act to submit monthly billing claims for reimbursement

1 purposes. Following development of these procedures, the
2 Department shall have an additional 365 days to test the
3 viability of the new system and to ensure that any necessary
4 operational or structural changes to its information
5 technology platforms are implemented.

6 The Illinois Department shall require all dispensers of
7 medical services, other than an individual practitioner or
8 group of practitioners, desiring to participate in the Medical
9 Assistance program established under this Article to disclose
10 all financial, beneficial, ownership, equity, surety or other
11 interests in any and all firms, corporations, partnerships,
12 associations, business enterprises, joint ventures, agencies,
13 institutions or other legal entities providing any form of
14 health care services in this State under this Article.

15 The Illinois Department may require that all dispensers of
16 medical services desiring to participate in the medical
17 assistance program established under this Article disclose,
18 under such terms and conditions as the Illinois Department may
19 by rule establish, all inquiries from clients and attorneys
20 regarding medical bills paid by the Illinois Department, which
21 inquiries could indicate potential existence of claims or
22 liens for the Illinois Department.

23 Enrollment of a vendor shall be subject to a provisional
24 period and shall be conditional for one year. During the
25 period of conditional enrollment, the Department may terminate
26 the vendor's eligibility to participate in, or may disenroll

1 the vendor from, the medical assistance program without cause.
2 Unless otherwise specified, such termination of eligibility or
3 disenrollment is not subject to the Department's hearing
4 process. However, a disenrolled vendor may reapply without
5 penalty.

6 The Department has the discretion to limit the conditional
7 enrollment period for vendors based upon category of risk of
8 the vendor.

9 Prior to enrollment and during the conditional enrollment
10 period in the medical assistance program, all vendors shall be
11 subject to enhanced oversight, screening, and review based on
12 the risk of fraud, waste, and abuse that is posed by the
13 category of risk of the vendor. The Illinois Department shall
14 establish the procedures for oversight, screening, and review,
15 which may include, but need not be limited to: criminal and
16 financial background checks; fingerprinting; license,
17 certification, and authorization verifications; unscheduled or
18 unannounced site visits; database checks; prepayment audit
19 reviews; audits; payment caps; payment suspensions; and other
20 screening as required by federal or State law.

21 The Department shall define or specify the following: (i)
22 by provider notice, the "category of risk of the vendor" for
23 each type of vendor, which shall take into account the level of
24 screening applicable to a particular category of vendor under
25 federal law and regulations; (ii) by rule or provider notice,
26 the maximum length of the conditional enrollment period for

1 each category of risk of the vendor; and (iii) by rule, the
2 hearing rights, if any, afforded to a vendor in each category
3 of risk of the vendor that is terminated or disenrolled during
4 the conditional enrollment period.

5 To be eligible for payment consideration, a vendor's
6 payment claim or bill, either as an initial claim or as a
7 resubmitted claim following prior rejection, must be received
8 by the Illinois Department, or its fiscal intermediary, no
9 later than 180 days after the latest date on the claim on which
10 medical goods or services were provided, with the following
11 exceptions:

12 (1) In the case of a provider whose enrollment is in
13 process by the Illinois Department, the 180-day period
14 shall not begin until the date on the written notice from
15 the Illinois Department that the provider enrollment is
16 complete.

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

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

24 (4) In the case of a provider operated by a unit of
25 local government with a population exceeding 3,000,000
26 when local government funds finance federal participation

1 for claims payments.
2 For claims for services rendered during a period for which
3 a recipient received retroactive eligibility, claims must be
4 filed within 180 days after the Department determines the
5 applicant is eligible. For claims for which the Illinois
6 Department is not the primary payer, claims must be submitted
7 to the Illinois Department within 180 days after the final
8 adjudication by the primary payer.
9 In the case of long term care facilities, within 45
10 calendar days of receipt by the facility of required
11 prescreening information, new admissions with associated
12 admission documents shall be submitted through the Medical
13 Electronic Data Interchange (MEDI) or the Recipient
14 Eligibility Verification (REV) System or shall be submitted
15 directly to the Department of Human Services using required
16 admission forms. Effective September 1, 2014, admission
17 documents, including all prescreening information, must be
18 submitted through MEDI or REV. Confirmation numbers assigned
19 to an accepted transaction shall be retained by a facility to
20 verify timely submittal. Once an admission transaction has
21 been completed, all resubmitted claims following prior
22 rejection are subject to receipt no later than 180 days after
23 the admission transaction has been completed.
24 Claims that are not submitted and received in compliance
25 with the foregoing requirements shall not be eligible for
26 payment under the medical assistance program, and the State

1 shall have no liability for payment of those claims.
2 To the extent consistent with applicable information and
3 privacy, security, and disclosure laws, State and federal
4 agencies and departments shall provide the Illinois Department
5 access to confidential and other information and data
6 necessary to perform eligibility and payment verifications and
7 other Illinois Department functions. This includes, but is not
8 limited to: information pertaining to licensure;
9 certification; earnings; immigration status; citizenship; wage
10 reporting; unearned and earned income; pension income;
11 employment; supplemental security income; social security
12 numbers; National Provider Identifier (NPI) numbers; the
13 National Practitioner Data Bank (NPDB); program and agency
14 exclusions; taxpayer identification numbers; tax delinquency;
15 corporate information; and death records.
16 The Illinois Department shall enter into agreements with
17 State agencies and departments, and is authorized to enter
18 into agreements with federal agencies and departments, under
19 which such agencies and departments shall share data necessary
20 for medical assistance program integrity functions and
21 oversight. The Illinois Department shall develop, in
22 cooperation with other State departments and agencies, and in
23 compliance with applicable federal laws and regulations,
24 appropriate and effective methods to share such data. At a
25 minimum, and to the extent necessary to provide data sharing,
26 the Illinois Department shall enter into agreements with State

1 agencies and departments, and is authorized to enter into
2 agreements with federal agencies and departments, including,
3 but not limited to: the Secretary of State; the Department of
4 Revenue; the Department of Public Health; the Department of
5 Human Services; and the Department of Financial and
6 Professional Regulation.

7 Beginning in fiscal year 2013, the Illinois Department
8 shall set forth a request for information to identify the
9 benefits of a pre-payment, post-adjudication, and post-edit
10 claims system with the goals of streamlining claims processing
11 and provider reimbursement, reducing the number of pending or
12 rejected claims, and helping to ensure a more transparent
13 adjudication process through the utilization of: (i) provider
14 data verification and provider screening technology; and (ii)
15 clinical code editing; and (iii) pre-pay, pre- or
16 post-adjudicated predictive modeling with an integrated case
17 management system with link analysis. Such a request for
18 information shall not be considered as a request for proposal
19 or as an obligation on the part of the Illinois Department to
20 take any action or acquire any products or services.

21 The Illinois Department shall establish policies,
22 procedures, standards and criteria by rule for the
23 acquisition, repair and replacement of orthotic and prosthetic
24 devices and durable medical equipment. Such rules shall
25 provide, but not be limited to, the following services: (1)
26 immediate repair or replacement of such devices by recipients;

1 and (2) rental, lease, purchase or lease-purchase of durable
2 medical equipment in a cost-effective manner, taking into
3 consideration the recipient's medical prognosis, the extent of
4 the recipient's needs, and the requirements and costs for
5 maintaining such equipment. Subject to prior approval, such
6 rules shall enable a recipient to temporarily acquire and use
7 alternative or substitute devices or equipment pending repairs
8 or replacements of any device or equipment previously
9 authorized for such recipient by the Department.
10 Notwithstanding any provision of Section 5-5f to the contrary,
11 the Department may, by rule, exempt certain replacement
12 wheelchair parts from prior approval and, for wheelchairs,
13 wheelchair parts, wheelchair accessories, and related seating
14 and positioning items, determine the wholesale price by
15 methods other than actual acquisition costs.

16 The Department shall require, by rule, all providers of
17 durable medical equipment to be accredited by an accreditation
18 organization approved by the federal Centers for Medicare and
19 Medicaid Services and recognized by the Department in order to
20 bill the Department for providing durable medical equipment to
21 recipients. No later than 15 months after the effective date
22 of the rule adopted pursuant to this paragraph, all providers
23 must meet the accreditation requirement.

24 In order to promote environmental responsibility, meet the
25 needs of recipients and enrollees, and achieve significant
26 cost savings, the Department, or a managed care organization

1 under contract with the Department, may provide recipients or
2 managed care enrollees who have a prescription or Certificate
3 of Medical Necessity access to refurbished durable medical
4 equipment under this Section (excluding prosthetic and
5 orthotic devices as defined in the Orthotics, Prosthetics, and
6 Pedorthics Practice Act and complex rehabilitation technology
7 products and associated services) through the State's
8 assistive technology program's reutilization program, using
9 staff with the Assistive Technology Professional (ATP)
10 Certification if the refurbished durable medical equipment:
11 (i) is available; (ii) is less expensive, including shipping
12 costs, than new durable medical equipment of the same type;
13 (iii) is able to withstand at least 3 years of use; (iv) is
14 cleaned, disinfected, sterilized, and safe in accordance with
15 federal Food and Drug Administration regulations and guidance
16 governing the reprocessing of medical devices in health care
17 settings; and (v) equally meets the needs of the recipient or
18 enrollee. The reutilization program shall confirm that the
19 recipient or enrollee is not already in receipt of same or
20 similar equipment from another service provider, and that the
21 refurbished durable medical equipment equally meets the needs
22 of the recipient or enrollee. Nothing in this paragraph shall
23 be construed to limit recipient or enrollee choice to obtain
24 new durable medical equipment or place any additional prior
25 authorization conditions on enrollees of managed care
26 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 determination. The Department must adopt rules through the 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.

1 The Illinois Department shall develop and operate, in
2 cooperation with other State Departments and agencies and in
3 compliance with applicable federal laws and regulations,
4 appropriate and effective systems of health care evaluation
5 and programs for monitoring of utilization of health care
6 services and facilities, as it affects persons eligible for
7 medical assistance under this Code.

8 The Illinois Department shall report annually to the
9 General Assembly, no later than the second Friday in April of
10 1979 and each year thereafter, in regard to:

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

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

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

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

19 The period covered by each report shall be the 3 years
20 ending on the June 30 prior to the report. The report shall
21 include suggested legislation for consideration by the General
22 Assembly. The requirement for reporting to the General
23 Assembly shall be satisfied by filing copies of the report as
24 required by Section 3.1 of the General Assembly Organization
25 Act, and filing such additional copies with the State
26 Government Report Distribution Center for the General Assembly

1 as is required under paragraph (t) of Section 7 of the State
2 Library Act.
3 Rulemaking authority to implement Public Act 95-1045, if
4 any, is conditioned on the rules being adopted in accordance
5 with all provisions of the Illinois Administrative Procedure
6 Act and all rules and procedures of the Joint Committee on
7 Administrative Rules; any purported rule not so adopted, for
8 whatever reason, is unauthorized.
9 On and after July 1, 2012, the Department shall reduce any
10 rate of reimbursement for services or other payments or alter
11 any methodologies authorized by this Code to reduce any rate
12 of reimbursement for services or other payments in accordance
13 with Section 5-5e.
14 Because kidney transplantation can be an appropriate,
15 cost-effective alternative to renal dialysis when medically
16 necessary and notwithstanding the provisions of Section 1-11
17 of this Code, beginning October 1, 2014, the Department shall
18 cover kidney transplantation for noncitizens with end-stage
19 renal disease who are not eligible for comprehensive medical
20 benefits, who meet the residency requirements of Section 5-3
21 of this Code, and who would otherwise meet the financial
22 requirements of the appropriate class of eligible persons
23 under Section 5-2 of this Code. To qualify for coverage of
24 kidney transplantation, such person must be receiving
25 emergency renal dialysis services covered by the Department.
26 Providers under this Section shall be prior approved and

1 certified by the Department to perform kidney transplantation
2 and the services under this Section shall be limited to
3 services associated with kidney transplantation.

4 Notwithstanding any other provision of this Code to the
5 contrary, on or after July 1, 2015, all FDA approved forms of
6 medication assisted treatment prescribed for the treatment of
7 alcohol dependence or treatment of opioid dependence shall be
8 covered under both fee for service and managed care medical
9 assistance programs for persons who are otherwise eligible for
10 medical assistance under this Article and shall not be subject
11 to any (1) utilization control, other than those established
12 under the American Society of Addiction Medicine patient
13 placement criteria, (2) prior authorization mandate, or (3)
14 lifetime restriction limit mandate.

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

1 Upon federal approval, the Department shall provide
2 coverage and reimbursement for all drugs that are approved for
3 marketing by the federal Food and Drug Administration and that
4 are recommended by the federal Public Health Service or the
5 United States Centers for Disease Control and Prevention for
6 pre-exposure prophylaxis and related pre-exposure prophylaxis
7 services, including, but not limited to, HIV and sexually
8 transmitted infection screening, treatment for sexually
9 transmitted infections, medical monitoring, assorted labs, and
10 counseling to reduce the likelihood of HIV infection among
11 individuals who are not infected with HIV but who are at high
12 risk of HIV infection.

13 A federally qualified health center, as defined in Section
14 1905(l)(2)(B) of the federal Social Security Act, shall be
15 reimbursed by the Department in accordance with the federally
16 qualified health center's encounter rate for services provided
17 to medical assistance recipients that are performed by a
18 dental hygienist, as defined under the Illinois Dental
19 Practice Act, working under the general supervision of a
20 dentist and employed by a federally qualified health center.

21 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
22 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
23 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
24 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
25 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
26 1-1-20; revised 9-18-19.)

1 (305 ILCS 5/5-5.01a)
2 Sec. 5-5.01a. Supportive living facilities program.
3 (a) The Department shall establish and provide oversight
4 for a program of supportive living facilities that seek to
5 promote resident independence, dignity, respect, and
6 well-being in the most cost-effective manner.
7 A supportive living facility is (i) a free-standing
8 facility or (ii) a distinct physical and operational entity
9 within a mixed-use building that meets the criteria
10 established in subsection (d). A supportive living facility
11 integrates housing with health, personal care, and supportive
12 services and is a designated setting that offers residents
13 their own separate, private, and distinct living units.
14 Sites for the operation of the program shall be selected
15 by the Department based upon criteria that may include the
16 need for services in a geographic area, the availability of
17 funding, and the site's ability to meet the standards.
18 (b) Beginning July 1, 2014, subject to federal approval,
19 the Medicaid rates for supportive living facilities shall be
20 equal to the supportive living facility Medicaid rate
21 effective on June 30, 2014 increased by 8.85%. Once the
22 assessment imposed at Article V-G of this Code is determined
23 to be a permissible tax under Title XIX of the Social Security
24 Act, the Department shall increase the Medicaid rates for
25 supportive living facilities effective on July 1, 2014 by

1 9.09%. The Department shall apply this increase retroactively
2 to coincide with the imposition of the assessment in Article
3 V-G of this Code in accordance with the approval for federal
4 financial participation by the Centers for Medicare and
5 Medicaid Services.

6 The Medicaid rates for supportive living facilities
7 effective on July 1, 2017 must be equal to the rates in effect
8 for supportive living facilities on June 30, 2017 increased by
9 2.8%.

10 Subject to federal approval, the Medicaid rates for
11 supportive living services on and after July 1, 2019 must be at
12 least 54.3% of the average total nursing facility services per
13 diem for the geographic areas defined by the Department while
14 maintaining the rate differential for dementia care and must
15 be updated whenever the total nursing facility service per
16 diems are updated.

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

24 (d) Subject to federal approval by the Centers for
25 Medicare and Medicaid Services, the Department shall accept
26 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 the provision of supportive living program services, including separate entrances;

(3) those distinct parts of the site or building do not share any common spaces with the part of the building used for the provision of supportive living program services; and

(4) those distinct parts of the site or building do not share staffing with the part of the building used for the provision of supportive living program services.

(e) Facilities or distinct parts of facilities which are selected as supportive living facilities and are in good standing with the Department's rules are exempt from the provisions of the Nursing Home Care Act and the Illinois Health Facilities Planning Act.

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

1 term care services until the State receives federal approval
2 and implements an updated assessment tool, and those
3 individuals are found to be ineligible under that updated
4 assessment tool. Anyone determined to be ineligible for
5 services due to the updated assessment tool shall continue to
6 be eligible for services for at least one year following that
7 determination and must be reassessed no earlier than 11 months
8 after that determination. The Department must adopt rules
9 through the regular rulemaking process regarding the updated
10 assessment tool, and shall not adopt emergency or peremptory
11 rules regarding the updated assessment tool. The State shall
12 not implement an updated assessment tool that causes more than
13 1% of then-current recipients to lose eligibility. No
14 individual receiving care in an institutional setting shall be
15 involuntarily discharged as the result of the updated
16 assessment tool until a transition plan has been developed by
17 the Department on Aging or its designee and all care
18 identified in the transition plan is available to the resident
19 immediately upon discharge.
20 (Source: P.A. 100-23, eff. 7-6-17; 100-583, eff. 4-6-18;
21 100-587, eff. 6-4-18; 101-10, eff. 6-5-19.)

22 Section 99. Effective date. This Act takes effect upon
23 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