HB5586

LRB10225158KTG34421b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB5586

Introduced 1/31/2022, by Rep. Camille Y. Lilly

SYNOPSIS AS INTRODUCED:

20 ILCS 105/4.02	from Ch. 23, par. 6104.02
20 ILCS 2405/3	from Ch. 23, par. 3434
305 ILCS 5/5-5	from Ch. 23, par. 5-5
305 ILCS 5/5-5.01a	

Amends the Illinois Act on the Aging, the Disabled Persons Rehabilitation Act, and the Illinois Public Aid Code. Regarding services provided under the Community Care Program, the Home Services Program, and the supportive living facilities program, provides that, through December 31, 2022, individuals who reside in rural and other underserved communities that are disproportionately impacted by COVID-19 shall be exempt from determination of need approval for institutional and home and community-based long term services. Provides that beginning on the effective date of the amendatory Act through December 31, 2022, any hours of home health services, home health care services, in-home care services, or adult day health services not utilized in accordance with an individual's service plan due to staff shortages resulting from the COVID-19 public health emergency shall roll over into the next service month under the individual's plan. Effective immediately.

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A BILL FOR

AN ACT concerning long term care services.

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

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

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

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

(a) (blank);

(b) (blank);

(c) home care aide services;

(d) personal assistant services;

(e) adult day services;

(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.

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

Notwithstanding any other law or rule, beginning on the effective date of this amendatory Act of the 102nd General

Assembly through December 31, 2022, individuals who reside in rural and other underserved communities that are disproportionately impacted by COVID-19 shall be exempt from determination of need approval for institutional and home and community-based long term services. Notwithstanding any other law or rule, beginning on the effective date of this amendatory Act of the 102nd General Assembly through December 31, 2022, any hours of in-home care or adult day health services not utilized in accordance with an individual's service plan due to staff shortages resulting from the COVID-19 public health emergency shall roll over into the next service month under the individual's plan. The Department may adopt rules to implement this paragraph.

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

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

1924 of the Social Security Act. Subject to the approval of such amendments, the Department shall extend the provisions of Section 5-4 of the Illinois Public Aid Code to persons who, but for the provision of home or community-based services, would require the level of care provided in an institution, as is provided for in federal law. Those persons no longer found to be eligible for receiving noninstitutional services due to changes in the eligibility criteria shall be given 45 days notice prior to actual termination. Those persons receiving notice of termination may contact the Department and request the determination be appealed at any time during the 45 day notice period. The target population identified for the purposes of this Section are persons age 60 and older with an identified service need. Priority shall be given to those who are at imminent risk of institutionalization. The services shall be provided to eligible persons age 60 and older to the extent that the cost of the services together with the other personal maintenance expenses of the persons are reasonably related to the standards established for care in a group facility appropriate to the person's condition. These non-institutional services, pilot projects or experimental facilities may be provided as part of or in addition to those authorized by federal law or those funded and administered by the Department of Human Services. The Departments of Human Services, Healthcare and Family Services, Public Health, Veterans' Affairs, and Commerce and Economic Opportunity and

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

As part of the Department on Aging's routine training of case managers and case manager supervisors, the Department may include information on family futures planning for persons who are age 60 or older and who are caregivers of their adult

children with developmental disabilities. The content of the training shall be at the Department's discretion.

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

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

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

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

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

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

to implement this item (2);

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

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

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

(A) bathing;

(B) grooming;

(C) toileting;

(D) nail care;

(E) transferring;

(F) respiratory services;

(G) exercise; or

(H) positioning;

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

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

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

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

the CCP program; the policy directive shall clarify service authorization guidelines to Care Coordination Units and Community Care Program providers no later than May 1, 2013;

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

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

(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.

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

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

Nominations may be presented from any agency or State association with interest in the program. The Director, or his or her designee, shall serve as the permanent co-chair of the advisory committee. One other co-chair shall be nominated and approved by the members of the committee on an annual basis. Committee members' terms of appointment shall be for 4 years with one-quarter of the appointees' terms expiring each year. A member shall continue to serve until his or her replacement is named. The Department shall fill vacancies that have a remaining term of over one year, and this replacement shall occur through the annual replacement of expiring terms. The Director shall designate Department staff to provide technical assistance and staff support to the committee. Department representation shall not constitute membership of the committee. All Committee papers, issues, recommendations, reports, and meeting memoranda are advisory only. The Director, or his or her designee, shall make a written report, as requested by the Committee, regarding issues before the Committee.

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

The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required

by Section 3.1 of the General Assembly Organization Act and filing such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

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

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

The Department shall implement an electronic service 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. Each provider, upon submission of any bill or invoice to the Department for payment for services rendered, shall include a notarized statement, under penalty of perjury pursuant to

Section 1-109 of the Code of Civil Procedure, that the provider has complied with all Department policies.

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

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

The General Assembly finds it necessary to authorize an aggressive Medicaid enrollment initiative designed to maximize federal Medicaid funding for the Community Care Program which

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

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

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

(2) One representative of the Department of Healthcare 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 the House of Representatives.

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

Leader of the House of Representatives.

(14) One individual appointed by a labor organization representing frontline employees at the Department of Human Services.

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

receive services under the Community Care Program and are eligible for medical assistance benefits but are not enrolled in the State's Medicaid Assistance Program. The data 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 provide targeted funding to care coordination units to help seniors complete their applications for medical assistance benefits. On and after July 1, 2019, care coordination units

shall receive no less than $200 per completed application, which rate may be included in a bundled rate for initial intake services when Medicaid application assistance is provided in conjunction with the initial intake process for new program participants.

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

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

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

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

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

(a) To cooperate with the federal government in the administration of the provisions of the federal Rehabilitation Act of 1973, as amended by the Workforce Innovation and Opportunity Act, and of the federal Social 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 vocational rehabilitation of persons with one or more disabilities, including the administrative activities under subsection (e) of this Section; to cooperate with State and local school authorities and other recognized agencies engaged in vocational rehabilitation services; and to cooperate with the Department of Children and Family Services, the Illinois State Board of Education, and others regarding the 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) information on the programs and activities dedicated to vocational rehabilitation, independent living, and other community services and supports administered by the Director; (2) information on the development of vocational rehabilitation services, independent living services, and supporting services administered by the Director in the State; and (3) information detailing 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; provided, however, that any portion of a person's income that is equal to or less than the "protected income" level shall not be considered by the Department in determining eligibility. The "protected income" level shall be

determined by the Department, shall never be less than the federal poverty standard, and shall be adjusted each year to reflect changes in the Consumer Price Index For All Urban Consumers as determined by the United States Department of Labor. The standards must provide that a person may not have more than $10,000 in assets to be eligible for the services, and the Department may increase or decrease the asset limitation by rule. The Department may not decrease the asset level below $10,000.

Notwithstanding any other law or rule, beginning on the effective date of this amendatory Act of the 102nd General Assembly through December 31, 2022, individuals who reside in rural and other underserved communities that are disproportionately impacted by COVID-19 shall be exempt from determination of need approval for institutional and home and community-based long term services. Notwithstanding any other law or rule, beginning on the effective date of this amendatory Act of the 102nd General Assembly through December 31, 2022, any hours of home health services not utilized in accordance with an individual's service plan due to staff shortages resulting from the COVID-19 public health emergency shall roll over into the next service month under the individual's plan. The Department may adopt rules to implement this paragraph.

The services shall be provided, as established by the

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

Except as otherwise provided in this paragraph, personal assistants shall be paid at a rate negotiated between the State and an exclusive representative of personal assistants under a collective bargaining 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 workers who function as personal assistants and individual maintenance home health workers working under the Home Services Program concerning their terms and conditions of employment that are within the State's control. Nothing in this paragraph shall be understood to limit the right of the persons receiving services defined in this Section to hire and fire home care and home health workers who function as personal assistants and individual maintenance

home health workers working under the Home Services Program or to supervise them within the limitations set by the Home Services Program. The State shall not be considered to be the employer of home care and home health workers who function as personal assistants and individual maintenance home health workers working under the Home Services Program for any purposes not specifically provided in Public Act 93-204 or Public Act 97-1158, including but not limited to, purposes of vicarious liability in tort and purposes of statutory retirement or health insurance benefits. 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 not be covered by the State Employees Group Insurance Act of 1971.

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

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

To the extent permitted under the federal Social Security Act, the Department, or the Department's authorized representative, may recover the amount of moneys expended for services provided to or in behalf of a person under this Section by a claim against the person's estate or against the estate of the person's surviving spouse, but no recovery may be had until after the death of the surviving spouse, if any, and then only at such time when there is no surviving child who is under age 21 or blind or who has a permanent and total disability. This paragraph, however, shall not bar recovery, at the death of the person, of moneys for services provided to the person or in behalf of the person under this Section to

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

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

(h) To cooperate and enter into any necessary agreements with the Department of Employment Security for

the provision of job placement and job referral services to clients of the Department, including job service registration of such clients with Illinois Employment Security offices and making job listings maintained by the Department of Employment Security available to such clients.

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

(j) (Blank).

(k) (Blank).

(l) To establish, operate, and maintain a Statewide Housing Clearinghouse of information on available government subsidized housing accessible to persons with disabilities and available privately owned housing accessible to persons with disabilities. The information shall include, but not be limited to, the location, rental requirements, access features and proximity to public transportation of available housing. The Clearinghouse shall consist of at least a computerized database for the storage and retrieval of information and a separate or shared toll free telephone number for use by those seeking information from the Clearinghouse. Department offices and personnel throughout the State shall also assist in the operation of the Statewide Housing Clearinghouse.

Cooperation with local, State, and federal housing managers shall be sought and extended in order to frequently and promptly update the Clearinghouse's information.

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

(Source: P.A. 102-264, eff. 8-6-21.)

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

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate

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

and evaluation process inclusive of criteria, for children and adults; for purposes of this item (13), a uniform screening, assessment, and evaluation process refers to a process that includes an appropriate evaluation and, as warranted, a referral; "uniform" does not mean the use of a singular instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; (16.5) services performed by a chiropractic physician licensed under the Medical Practice Act of 1987 and acting within the scope of his or her license, including, but not limited to, chiropractic manipulative treatment; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

Notwithstanding any other provision of this Section, a comprehensive tobacco use cessation program that includes purchasing prescription drugs or prescription medical devices approved by the Food and Drug Administration shall be covered

under the medical assistance program under this Article for persons who are otherwise eligible for assistance under this Article.

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

Notwithstanding any other provision of this Section, all tobacco cessation medications approved by the United States Food and Drug Administration and all individual and group tobacco cessation counseling services and telephone-based counseling services and tobacco cessation medications provided through the Illinois Tobacco Quitline shall be covered under the medical assistance program for persons who are otherwise eligible for assistance under this Article. The Department shall comply with all federal requirements necessary to obtain federal financial participation, as specified in 42 CFR 433.15(b)(7), for telephone-based counseling services provided through the Illinois Tobacco Quitline, including, but not limited to: (i) entering into a memorandum of understanding or interagency agreement with the Department of Public Health, as administrator of the Illinois Tobacco Quitline; and (ii) developing a cost allocation plan for Medicaid-allowable Illinois Tobacco Quitline services in accordance with 45 CFR 95.507. The Department shall submit the memorandum of

understanding or interagency agreement, the cost allocation plan, and all other necessary documentation to the Centers for Medicare and Medicaid Services for review and approval. Coverage under this paragraph shall be contingent upon federal approval.

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

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

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

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

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

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

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

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

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

On and after January 1, 2022, the Department of Healthcare and Family Services shall administer and regulate a school-based dental program that allows for the out-of-office

delivery of preventative dental services in a school setting to children under 19 years of age. The Department shall establish, by rule, guidelines for participation by providers and set requirements for follow-up referral care based on the requirements established in the Dental Office Reference Manual published by the Department that establishes the requirements for dentists participating in the All Kids Dental School Program. Every effort shall be made by the Department when developing the program requirements to consider the different geographic differences of both urban and rural areas of the State for initial treatment and necessary follow-up care. No provider shall be charged a fee by any unit of local government to participate in the school-based dental program administered by the Department. Nothing in this paragraph shall be construed to limit or preempt a home rule unit's or school district's authority to establish, change, or administer a school-based dental program in addition to, or independent of, the school-based dental program administered by the Department.

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

The Department of Healthcare and Family Services must provide coverage and reimbursement for amino acid-based elemental formulas, regardless of delivery method, for the

diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

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

(A) A baseline mammogram for individuals 35 to 39 years of age.

(B) An annual mammogram for individuals 40 years of age or older.

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

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

(E) A screening MRI when medically necessary, as determined by a physician licensed to practice medicine in

all of its branches.

(F) A diagnostic mammogram when medically necessary, as determined by a physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant.

The Department shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided under this paragraph; except that this sentence does not apply to coverage of diagnostic mammograms to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to Section 223 of the Internal Revenue Code (26 U.S.C. 223).

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

For purposes of this Section:

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

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

"Low-dose mammography" means the x-ray examination of the

breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with an average radiation exposure delivery of less than one rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis.

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

If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this paragraph.

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

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

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

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

The Department shall convene an expert panel, including representatives of hospitals, free-standing breast cancer treatment centers, breast cancer quality organizations, and doctors, including breast surgeons, reconstructive breast surgeons, oncologists, and primary care providers to establish quality standards for breast cancer treatment.

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

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

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

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of

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

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

On or after July 1, 2022, individuals who are otherwise eligible for medical assistance under this Article shall receive coverage for perinatal depression screenings for the 12-month period beginning on the last day of their pregnancy. Medical assistance coverage under this paragraph shall be conditioned on the use of a screening instrument approved by the Department.

Any medical or health care provider shall immediately

recommend, to any pregnant individual who is being provided prenatal services and is suspected of having a substance use disorder as defined in the Substance Use Disorder Act, referral to a local substance use disorder treatment program licensed by the Department of Human Services or to a licensed hospital which provides substance abuse treatment services. The Department of Healthcare and Family Services shall assure coverage for the cost of treatment of the drug abuse or addiction for pregnant recipients in accordance with the Illinois Medicaid Program in conjunction with the Department of Human Services.

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

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

Neither the Department of Healthcare and Family Services nor the Department of Human Services shall sanction the recipient solely on the basis of the recipient's substance abuse.

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

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

The sponsor must negotiate formal written contracts with medical providers for physician services, inpatient and outpatient hospital care, home health services, treatment for

alcoholism and substance abuse, and other services determined necessary by the Illinois Department by rule for delivery by Partnerships. Physician services must include prenatal and obstetrical care. The Illinois Department shall reimburse medical services delivered by Partnership providers to clients in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

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

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

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

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

for participation by medical providers, only with the prior written approval of the Illinois Department.

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

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

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care

providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after September 16, 1984 (the effective date of Public Act 83-1439), the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that

the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

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

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

The Illinois Department shall require all dispensers of

medical services, other than an individual practitioner or group of practitioners, desiring to participate in the Medical Assistance program established under this Article to disclose all financial, beneficial, ownership, equity, surety or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services in this State under this Article.

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

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

The Department has the discretion to limit the conditional

enrollment period for vendors based upon category of risk of the vendor.

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

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

To be eligible for payment consideration, a vendor's payment claim or bill, either as an initial claim or as a

resubmitted claim following prior rejection, must be received by the Illinois Department, or its fiscal intermediary, no later than 180 days after the latest date on the claim on which medical goods or services were provided, with the following exceptions:

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

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

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

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

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

to the Illinois Department within 180 days after the final adjudication by the primary payer.

In the case of long term care facilities, within 120 calendar days of receipt by the facility of required prescreening information, new admissions with associated admission documents shall be submitted through the Medical Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System or shall be submitted directly to the Department of Human Services using required admission forms. Effective September 1, 2014, admission documents, including all prescreening information, must be submitted through MEDI or REV. Confirmation numbers assigned to an accepted transaction shall be retained by a facility to verify timely submittal. Once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.

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

To the extent consistent with applicable information and privacy, security, and disclosure laws, State and federal agencies and departments shall provide the Illinois Department access to confidential and other information and data necessary to perform eligibility and payment verifications and

other Illinois Department functions. This includes, but is not limited to: information pertaining to licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

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

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

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of the recipient's needs, and the requirements and costs for maintaining such equipment. Subject to prior approval, such rules shall enable a recipient to temporarily acquire and use

alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department. Notwithstanding any provision of Section 5-5f to the contrary, the Department may, by rule, exempt certain replacement wheelchair parts from prior approval and, for wheelchairs, wheelchair parts, wheelchair accessories, and related seating and positioning items, determine the wholesale price by methods other than actual acquisition costs.

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

In order to promote environmental responsibility, meet the needs of recipients and enrollees, and achieve significant cost savings, the Department, or a managed care organization under contract with the Department, may provide recipients or managed care enrollees who have a prescription or Certificate of Medical Necessity access to refurbished durable medical equipment under this Section (excluding prosthetic and orthotic devices as defined in the Orthotics, Prosthetics, and Pedorthics Practice Act and complex rehabilitation technology

products and associated services) through the State's assistive technology program's reutilization program, using staff with the Assistive Technology Professional (ATP) Certification if the refurbished durable medical equipment: (i) is available; (ii) is less expensive, including shipping costs, than new durable medical equipment of the same type; (iii) is able to withstand at least 3 years of use; (iv) is cleaned, disinfected, sterilized, and safe in accordance with federal Food and Drug Administration regulations and guidance governing the reprocessing of medical devices in health care settings; and (v) equally meets the needs of the recipient or enrollee. The reutilization program shall confirm that the recipient or enrollee is not already in receipt of the same or similar equipment from another service provider, and that the refurbished durable medical equipment equally meets the needs of the recipient or enrollee. Nothing in this paragraph shall be construed to limit recipient or enrollee choice to obtain new durable medical equipment or place any additional prior authorization conditions on enrollees of managed care organizations.

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and

development of non-institutional services in areas of the State where they are not currently available or are undeveloped; and (iii) notwithstanding any other provision of law, subject to federal approval, on and after July 1, 2012, an increase in the determination of need (DON) scores from 29 to 37 for applicants for institutional and home and community-based long term care; if and only if federal approval is not granted, the Department may, in conjunction with other affected agencies, implement utilization controls or changes in benefit packages to effectuate a similar savings amount for this population; and (iv) no later than July 1, 2013, minimum level of care eligibility criteria for institutional and home and community-based long term care; and (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.

Notwithstanding any other law or rule and subject to

federal approval, beginning on the effective date of this amendatory Act of the 102nd General Assembly through December 31, 2022, individuals who reside in rural and other underserved communities that are disproportionately impacted by COVID-19 shall be exempt from determination of need approval for institutional and home and community-based long term services. Notwithstanding any other law or rule, beginning on the effective date of this amendatory Act of the 102nd General Assembly through December 31, 2022, any hours of home health care services not utilized in accordance with an individual's service plan due to staff shortages resulting from the COVID-19 public health emergency shall roll over into the next service month under the individual's plan. The Department may adopt rules to implement this paragraph.

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

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

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

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

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

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

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

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

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

with Section 5-5e.

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

Notwithstanding any other provision of this Code to the contrary, on or after July 1, 2015, all FDA approved forms of medication assisted treatment prescribed for the treatment of alcohol dependence or treatment of opioid dependence shall be covered under both fee for service and managed care medical assistance programs for persons who are otherwise eligible for medical assistance under this Article and shall not be subject to any (1) utilization control, other than those established under the American Society of Addiction Medicine patient

placement criteria, (2) prior authorization mandate, or (3) lifetime restriction limit mandate.

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

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

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

Within 90 days after October 8, 2021 (the effective date of Public Act 102-665) ~~this amendatory Act of the 102nd General Assembly~~, the Department shall seek federal approval of a State Plan amendment to expand coverage for family planning services that includes presumptive eligibility to individuals whose income is at or below 208% of the federal poverty level. Coverage under this Section shall be effective beginning no later than December 1, 2022.

Subject to approval by the federal Centers for Medicare and Medicaid Services of a Title XIX State Plan amendment electing the Program of All-Inclusive Care for the Elderly (PACE) as a State Medicaid option, as provided for by Subtitle I (commencing with Section 4801) of Title IV of the Balanced Budget Act of 1997 (Public Law 105-33) and Part 460 (commencing with Section 460.2) of Subchapter E of Title 42 of the Code of Federal Regulations, PACE program services shall become a covered benefit of the medical assistance program, subject to criteria established in accordance with all

applicable laws.

Notwithstanding any other provision of this Code, community-based pediatric palliative care from a trained interdisciplinary team shall be covered under the medical assistance program as provided in Section 15 of the Pediatric Palliative Care Act.

(Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20; 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; revised 11-18-21.)

(305 ILCS 5/5-5.01a)

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

(a) The Department shall establish and provide oversight for a program of supportive living facilities that seek to promote resident independence, dignity, respect, and well-being in the most cost-effective manner.

A supportive living facility is (i) a free-standing facility or (ii) a distinct physical and operational entity within a mixed-use building that meets the criteria established in subsection (d). A supportive living facility integrates housing with health, personal care, and supportive services and is a designated setting that offers residents their own separate, private, and distinct living units.

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

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

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

Subject to federal approval, the Medicaid rates for supportive living services on and after July 1, 2019 must be at least 54.3% of the average total nursing facility services per diem for the geographic areas defined by the Department while maintaining the rate differential for dementia care and must

be updated whenever the total nursing facility service per diems are updated.

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

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

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

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

(f) Section 9817 of the American Rescue Plan Act of 2021 (Public Law 117-2) authorizes a 10% enhanced federal medical assistance percentage for supportive living services for a 12-month period from April 1, 2021 through March 31, 2022. Subject to federal approval, including the approval of any necessary waiver amendments or other federally required documents or assurances, for a 12-month period the Department must pay a supplemental $26 per diem rate to all supportive living facilities with the additional federal financial participation funds that result from the enhanced federal medical assistance percentage from April 1, 2021 through March 31, 2022. The Department may issue parameters around how the supplemental payment should be spent, including quality improvement activities. The Department may alter the form, methods, or timeframes concerning the supplemental per diem rate to comply with any subsequent changes to federal law, changes made by guidance issued by the federal Centers for

Medicare and Medicaid Services, or other changes necessary to receive the enhanced federal medical assistance percentage.

(g) Notwithstanding any other law or rule, beginning on the effective date of this amendatory Act of the 102nd General Assembly through December 31, 2022, individuals who reside in rural and other underserved communities that are disproportionately impacted by COVID-19 shall be exempt from determination of need approval for institutional and home and community-based long term services. Notwithstanding any other law or rule, beginning on the effective date of this amendatory Act of the 102nd General Assembly through December 31, 2022, any hours of home health care services not utilized in accordance with an individual's service plan due to staff shortages resulting from the COVID-19 public health emergency shall roll over into the next service month under the individual's plan. The Department may adopt rules to implement this paragraph.

(Source: P.A. 101-10, eff. 6-5-19; 102-43, eff. 7-6-21.)

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