HB1184

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB1184

Introduced 1/31/2023, by Rep. Maurice A. West, II

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 5/5-2b	
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 Rehabilitation of Persons with Disabilities Act, and the Illinois Public Aid Code. Provides that individuals with a score of 29 or higher based on the determination of need (DON) assessment tool shall be eligible to receive services through the Community Care Program, services to prevent unnecessary or premature institutionalization, and services through the program of supportive living facilities. Further amends the Illinois Public Aid Code. Provides that on and after July 1, 2025, level of care eligibility criteria for home and community-based services for medically fragile and technology dependent children shall be no more restrictive than the level of care criteria in place on January 1, 2023. Requires the Department of Healthcare and Family Services to execute, relative to the nursing home prescreening project, written agreements with the Department of Human Services and the Department on Aging to effect, on and after July 1, 2025, an increase in the DON score threshold to 37 for applicants for institutional long term care, subject to federal approval. Provides that on and after July 1, 2025 but before July 1, 2027, continuation of a nursing facility stay that began on or before June 30, 2025 by a person with a DON score between 29 and 36 may be covered when such stay would be otherwise eligible under this Code, provided the nursing facility performs certain actions. Requires the Department to, by rule, set a maximum total number of individuals to be covered and other limits on utilization that it deems appropriate. Effective July 1, 2025.

LRB103 05292 KTG 50310 b

A BILL FOR

1 AN ACT concerning home and community-based services.

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

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

6 (20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)
7 Sec. 4.02. Community Care Program. The Department shall
8 establish a program of services to prevent unnecessary
9 institutionalization of persons age 60 and older in need of
10 long term care or who are established as persons who suffer
11 from Alzheimer's disease or a related disorder under the
12 Alzheimer's Disease Assistance Act, thereby enabling them to
13 remain in their own homes or in other living arrangements.
14 Such preventive services, which may be coordinated with other
15 programs for the aged and monitored by area agencies on aging
16 in cooperation with the Department, may include, but are not
17 limited to, any or all of the following:
18 (a) (blank);
19 (b) (blank);
20 (c) home care aide services;
21 (d) personal assistant services;
22 (e) adult day services;
23 (f) home-delivered meals;

(g) education in self-care;

(h) personal care services;

(i) adult day health services;

(j) habilitation services;

(k) respite care;

(k-5) community reintegration services;

(k-6) flexible senior services;

(k-7) medication management;

(k-8) emergency home response;

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

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

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.

Beginning January 1, 2008, the Department shall require as a condition of eligibility that all new financially eligible

1 applicants apply for and enroll in medical assistance under
2 Article V of the Illinois Public Aid Code in accordance with
3 rules promulgated by the Department.

4 The Department shall, in conjunction with the Department
5 of Public Aid (now Department of Healthcare and Family
6 Services), seek appropriate amendments under Sections 1915 and
7 1924 of the Social Security Act. The purpose of the amendments
8 shall be to extend eligibility for home and community based
9 services under Sections 1915 and 1924 of the Social Security
10 Act to persons who transfer to or for the benefit of a spouse
11 those amounts of income and resources allowed under Section
12 1924 of the Social Security Act. Subject to the approval of
13 such amendments, the Department shall extend the provisions of
14 Section 5-4 of the Illinois Public Aid Code to persons who, but
15 for the provision of home or community-based services, would
16 require the level of care provided in an institution, as is
17 provided for in federal law. Those persons no longer found to
18 be eligible for receiving noninstitutional services due to
19 changes in the eligibility criteria shall be given 45 days
20 notice prior to actual termination. Those persons receiving
21 notice of termination may contact the Department and request
22 the determination be appealed at any time during the 45 day
23 notice period. The target population identified for the
24 purposes of this Section are persons age 60 and older with an
25 identified service need. Priority shall be given to those who
26 are at imminent risk of institutionalization. The services

1 shall be provided to eligible persons age 60 and older to the
2 extent that the cost of the services together with the other
3 personal maintenance expenses of the persons are reasonably
4 related to the standards established for care in a group
5 facility appropriate to the person's condition. These
6 non-institutional services, pilot projects or experimental
7 facilities may be provided as part of or in addition to those
8 authorized by federal law or those funded and administered by
9 the Department of Human Services. The Departments of Human
10 Services, Healthcare and Family Services, Public Health,
11 Veterans' Affairs, and Commerce and Economic Opportunity and
12 other appropriate agencies of State, federal and local
13 governments shall cooperate with the Department on Aging in
14 the establishment and development of the non-institutional
15 services. The Department shall require an annual audit from
16 all personal assistant and home care aide vendors contracting
17 with the Department under this Section. The annual audit shall
18 assure that each audited vendor's procedures are in compliance
19 with Department's financial reporting guidelines requiring an
20 administrative and employee wage and benefits cost split as
21 defined in administrative rules. The audit is a public record
22 under the Freedom of Information Act. The Department shall
23 execute, relative to the nursing home prescreening project,
24 written inter-agency agreements with the Department of Human
25 Services and the Department of Healthcare and Family Services,
26 to effect the following: (1) intake procedures and common

1 eligibility criteria for those persons who are receiving
2 non-institutional services; and (2) the establishment and
3 development of non-institutional services in areas of the
4 State where they are not currently available or are
5 undeveloped. On and after July 1, 1996, all nursing home
6 prescreenings for individuals 60 years of age or older shall
7 be conducted by the Department.

8 As part of the Department on Aging's routine training of
9 case managers and case manager supervisors, the Department may
10 include information on family futures planning for persons who
11 are age 60 or older and who are caregivers of their adult
12 children with developmental disabilities. The content of the
13 training shall be at the Department's discretion.

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

24 The Department, or the Department's authorized
25 representative, may recover the amount of moneys expended for
26 services provided to or in behalf of a person under this

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

1 Individuals with a score of 29 or higher based on the
2 determination of need assessment tool shall be eligible to
3 receive services through the Community Care Program.
4 The Department shall increase the effectiveness of the
5 existing Community Care Program by:
6 (1) ensuring that in-home services included in the
7 care plan are available on evenings and weekends;
8 (2) ensuring that care plans contain the services that
9 eligible participants need based on the number of days in
10 a month, not limited to specific blocks of time, as
11 identified by the comprehensive assessment tool selected
12 by the Department for use statewide, not to exceed the
13 total monthly service cost maximum allowed for each
14 service; the Department shall develop administrative rules
15 to implement this item (2);
16 (3) ensuring that the participants have the right to
17 choose the services contained in their care plan and to
18 direct how those services are provided, based on
19 administrative rules established by the Department;
20 (4) ensuring that the determination of need tool is
21 accurate in determining the participants' level of need;
22 to achieve this, the Department, in conjunction with the
23 Older Adult Services Advisory Committee, shall institute a
24 study of the relationship between the Determination of
25 Need scores, level of need, service cost maximums, and the
26 development and utilization of service plans no later than

1 May 1, 2008; findings and recommendations shall be
2 presented to the Governor and the General Assembly no
3 later than January 1, 2009; recommendations shall include
4 all needed changes to the service cost maximums schedule
5 and additional covered services;
6 (5) ensuring that homemakers can provide personal care
7 services that may or may not involve contact with clients,
8 including but not limited to:
9 (A) bathing;
10 (B) grooming;
11 (C) toileting;
12 (D) nail care;
13 (E) transferring;
14 (F) respiratory services;
15 (G) exercise; or
16 (H) positioning;
17 (6) ensuring that homemaker program vendors are not
18 restricted from hiring homemakers who are family members
19 of clients or recommended by clients; the Department may
20 not, by rule or policy, require homemakers who are family
21 members of clients or recommended by clients to accept
22 assignments in homes other than the client;
23 (7) ensuring that the State may access maximum federal
24 matching funds by seeking approval for the Centers for
25 Medicare and Medicaid Services for modifications to the
26 State's home and community based services waiver and

1 additional waiver opportunities, including applying for
2 enrollment in the Balance Incentive Payment Program by May
3 1, 2013, in order to maximize federal matching funds; this
4 shall include, but not be limited to, modification that
5 reflects all changes in the Community Care Program
6 services and all increases in the services cost maximum;

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

10 (9) ensuring that services are authorized accurately
11 and consistently for the Community Care Program (CCP); the
12 Department shall implement a Service Authorization policy
13 directive; the purpose shall be to ensure that eligibility
14 and services are authorized accurately and consistently in
15 the CCP program; the policy directive shall clarify
16 service authorization guidelines to Care Coordination
17 Units and Community Care Program providers no later than
18 May 1, 2013;

19 (10) working in conjunction with Care Coordination
20 Units, the Department of Healthcare and Family Services,
21 the Department of Human Services, Community Care Program
22 providers, and other stakeholders to make improvements to
23 the Medicaid claiming processes and the Medicaid
24 enrollment procedures or requirements as needed,
25 including, but not limited to, specific policy changes or
26 rules to improve the up-front enrollment of participants

1 in the Medicaid program and specific policy changes or
2 rules to insure more prompt submission of bills to the
3 federal government to secure maximum federal matching
4 dollars as promptly as possible; the Department on Aging
5 shall have at least 3 meetings with stakeholders by
6 January 1, 2014 in order to address these improvements;
7 (11) requiring home care service providers to comply
8 with the rounding of hours worked provisions under the
9 federal Fair Labor Standards Act (FLSA) and as set forth
10 in 29 CFR 785.48(b) by May 1, 2013;
11 (12) implementing any necessary policy changes or
12 promulgating any rules, no later than January 1, 2014, to
13 assist the Department of Healthcare and Family Services in
14 moving as many participants as possible, consistent with
15 federal regulations, into coordinated care plans if a care
16 coordination plan that covers long term care is available
17 in the recipient's area; and
18 (13) maintaining fiscal year 2014 rates at the same
19 level established on January 1, 2013.
20 By January 1, 2009 or as soon after the end of the Cash and
21 Counseling Demonstration Project as is practicable, the
22 Department may, based on its evaluation of the demonstration
23 project, promulgate rules concerning personal assistant
24 services, to include, but need not be limited to,
25 qualifications, employment screening, rights under fair labor
26 standards, training, fiduciary agent, and supervision

1 requirements. All applicants shall be subject to the
2 provisions of the Health Care Worker Background Check Act.
3 The Department shall develop procedures to enhance
4 availability of services on evenings, weekends, and on an
5 emergency basis to meet the respite needs of caregivers.
6 Procedures shall be developed to permit the utilization of
7 services in successive blocks of 24 hours up to the monthly
8 maximum established by the Department. Workers providing these
9 services shall be appropriately trained.
10 Beginning on the effective date of this amendatory Act of
11 1991, no person may perform chore/housekeeping and home care
12 aide services under a program authorized by this Section
13 unless that person has been issued a certificate of
14 pre-service to do so by his or her employing agency.
15 Information gathered to effect such certification shall
16 include (i) the person's name, (ii) the date the person was
17 hired by his or her current employer, and (iii) the training,
18 including dates and levels. Persons engaged in the program
19 authorized by this Section before the effective date of this
20 amendatory Act of 1991 shall be issued a certificate of all
21 pre- and in-service training from his or her employer upon
22 submitting the necessary information. The employing agency
23 shall be required to retain records of all staff pre- and
24 in-service training, and shall provide such records to the
25 Department upon request and upon termination of the employer's
26 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

1 the Committee to represent provider, advocacy, policy
2 research, and other constituencies committed to the delivery
3 of high quality home and community-based services to older
4 adults. Representatives shall be appointed to ensure
5 representation from community care providers including, but
6 not limited to, adult day service providers, homemaker
7 providers, case coordination and case management units,
8 emergency home response providers, statewide trade or labor
9 unions that represent home care aides and direct care staff,
10 area agencies on aging, adults over age 60, membership
11 organizations representing older adults, and other
12 organizational entities, providers of care, or individuals
13 with demonstrated interest and expertise in the field of home
14 and community care as determined by the Director.

15 Nominations may be presented from any agency or State
16 association with interest in the program. The Director, or his
17 or her designee, shall serve as the permanent co-chair of the
18 advisory committee. One other co-chair shall be nominated and
19 approved by the members of the committee on an annual basis.
20 Committee members' terms of appointment shall be for 4 years
21 with one-quarter of the appointees' terms expiring each year.
22 A member shall continue to serve until his or her replacement
23 is named. The Department shall fill vacancies that have a
24 remaining term of over one year, and this replacement shall
25 occur through the annual replacement of expiring terms. The
26 Director shall designate Department staff to provide technical

1 assistance and staff support to the committee. Department
2 representation shall not constitute membership of the
3 committee. All Committee papers, issues, recommendations,
4 reports, and meeting memoranda are advisory only. The
5 Director, or his or her designee, shall make a written report,
6 as requested by the Committee, regarding issues before the
7 Committee.

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

13 The requirement for reporting to the General Assembly
14 shall be satisfied by filing copies of the report as required
15 by Section 3.1 of the General Assembly Organization Act and
16 filing such additional copies with the State Government Report
17 Distribution Center for the General Assembly as is required
18 under paragraph (t) of Section 7 of the State Library Act.

19 Those persons previously found eligible for receiving
20 non-institutional services whose services were discontinued
21 under the Emergency Budget Act of Fiscal Year 1992, and who do
22 not meet the eligibility standards in effect on or after July
23 1, 1992, shall remain ineligible on and after July 1, 1992.
24 Those persons previously not required to cost-share and who
25 were required to cost-share effective March 1, 1992, shall
26 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)

1 beginning August 1, 2013, if the Auditor General has reported
2 that the Department has failed to comply with the reporting
3 requirements of Section 2-27 of the Illinois State Auditing
4 Act; or (ii) beginning June 1, 2014, if the Auditor General has
5 reported that the Department has not undertaken the required
6 actions listed in the report required by subsection (a) of
7 Section 2-27 of the Illinois State Auditing Act.

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

18 The Department shall continue to provide other Community
19 Care Program reports as required by statute.

20 The Department shall conduct a quarterly review of Care
21 Coordination Unit performance and adherence to service
22 guidelines. The quarterly review shall be reported to the
23 Speaker of the House of Representatives, the Minority Leader
24 of the House of Representatives, the President of the Senate,
25 and the Minority Leader of the Senate. The Department shall
26 collect and report longitudinal data on the performance of

1 each care coordination unit. Nothing in this paragraph shall
2 be construed to require the Department to identify specific
3 care coordination units.

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

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

18 Within 30 days after July 6, 2017 (the effective date of
19 Public Act 100-23), rates shall be increased to $18.29 per
20 hour, for the purpose of increasing, by at least $.72 per hour,
21 the wages paid by those vendors to their employees who provide
22 homemaker services. The Department shall pay an enhanced rate
23 under the Community Care Program to those in-home service
24 provider agencies that offer health insurance coverage as a
25 benefit to their direct service worker employees consistent
26 with the mandates of Public Act 95-713. For State fiscal years

1 2018 and 2019, the enhanced rate shall be $1.77 per hour. The
2 rate shall be adjusted using actuarial analysis based on the
3 cost of care, but shall not be set below $1.77 per hour. The
4 Department shall adopt rules, including emergency rules under
5 subsections (y) and (bb) of Section 5-45 of the Illinois
6 Administrative Procedure Act, to implement the provisions of
7 this paragraph.

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

21 The Community Care Program Medicaid Enrollment Oversight
22 Subcommittee is created as a subcommittee of the Older Adult
23 Services Advisory Committee established in Section 35 of the
24 Older Adult Services Act to make recommendations on how best
25 to increase the number of medical assistance recipients who
26 are enrolled in the Community Care Program. The Subcommittee

1 shall consist of all of the following persons who must be
2 appointed within 30 days after the effective date of this
3 amendatory Act of the 100th General Assembly:
4 (1) The Director of Aging, or his or her designee, who
5 shall serve as the chairperson of the Subcommittee.
6 (2) One representative of the Department of Healthcare
7 and Family Services, appointed by the Director of
8 Healthcare and Family Services.
9 (3) One representative of the Department of Human
10 Services, appointed by the Secretary of Human Services.
11 (4) One individual representing a care coordination
12 unit, appointed by the Director of Aging.
13 (5) One individual from a non-governmental statewide
14 organization that advocates for seniors, appointed by the
15 Director of Aging.
16 (6) One individual representing Area Agencies on
17 Aging, appointed by the Director of Aging.
18 (7) One individual from a statewide association
19 dedicated to Alzheimer's care, support, and research,
20 appointed by the Director of Aging.
21 (8) One individual from an organization that employs
22 persons who provide services under the Community Care
23 Program, appointed by the Director of Aging.
24 (9) One member of a trade or labor union representing
25 persons who provide services under the Community Care
26 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

1 service area, who are receiving services under the Community
2 Care Program and are eligible for benefits under the State's
3 Medical Assistance Program, but are not enrolled in the
4 State's Medical Assistance Program. In addition to this data,
5 the Department on Aging shall provide the Subcommittee with
6 plans on how the Department on Aging will reduce the number of
7 Illinois residents who are not enrolled in the State's Medical
8 Assistance Program but who are eligible for medical assistance
9 benefits. The Department on Aging shall enroll in the State's
10 Medical Assistance Program those Illinois residents who
11 receive services under the Community Care Program and are
12 eligible for medical assistance benefits but are not enrolled
13 in the State's Medicaid Assistance Program. The data provided
14 to the Subcommittee shall be made available to the public via
15 the Department on Aging's website.

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

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

25 The Subcommittee shall collaborate with the Department of
26 Human Services on the adoption of a uniform application

1 submission process. The Department of Human Services and any
2 other State agency involved with processing the medical
3 assistance application of any person enrolled in the Community
4 Care Program shall include the appropriate care coordination
5 unit in all communications related to the determination or
6 status of the application.

7 The Community Care Program Medicaid Initiative shall
8 provide targeted funding to care coordination units to help
9 seniors complete their applications for medical assistance
10 benefits. On and after July 1, 2019, care coordination units
11 shall receive no less than $200 per completed application,
12 which rate may be included in a bundled rate for initial intake
13 services when Medicaid application assistance is provided in
14 conjunction with the initial intake process for new program
15 participants.

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

20 (Source: P.A. 101-10, eff. 6-5-19; 102-1071, eff. 6-10-22.)

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

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

24 Sec. 3. Powers and duties. The Department shall have the

1 powers and duties enumerated herein:
2 (a) To cooperate with the federal government in the
3 administration of the provisions of the federal
4 Rehabilitation Act of 1973, as amended by the Workforce
5 Innovation and Opportunity Act, and of the federal Social
6 Security Act to the extent and in the manner provided in
7 these Acts.
8 (b) To prescribe and supervise such courses of
9 vocational training and provide such other services as may
10 be necessary for the vocational rehabilitation of persons
11 with one or more disabilities, including the
12 administrative activities under subsection (e) of this
13 Section; to cooperate with State and local school
14 authorities and other recognized agencies engaged in
15 vocational rehabilitation services; and to cooperate with
16 the Department of Children and Family Services, the
17 Illinois State Board of Education, and others regarding
18 the education of children with one or more disabilities.
19 (c) (Blank).
20 (d) To report in writing, to the Governor, annually on
21 or before the first day of December, and at such other
22 times and in such manner and upon such subjects as the
23 Governor may require. The annual report shall contain (1)
24 information on the programs and activities dedicated to
25 vocational rehabilitation, independent living, and other
26 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.

1 The Department shall establish eligibility standards
2 for such services taking into consideration the unique
3 economic and social needs of the population for whom they
4 are to be provided. Such eligibility standards may be
5 based on the recipient's ability to pay for services;
6 provided, however, that any portion of a person's income
7 that is equal to or less than the "protected income" level
8 shall not be considered by the Department in determining
9 eligibility. The "protected income" level shall be
10 determined by the Department, shall never be less than the
11 federal poverty standard, and shall be adjusted each year
12 to reflect changes in the Consumer Price Index For All
13 Urban Consumers as determined by the United States
14 Department of Labor. The standards must provide that a
15 person may not have more than $10,000 in assets to be
16 eligible for the services, and the Department may increase
17 or decrease the asset limitation by rule. The Department
18 may not decrease the asset level below $10,000. Subject to
19 federal approval, the Department shall allow a recipient's
20 spouse to serve as his or her provider of personal care or
21 similar services.
22 Individuals with a score of 29 or higher based on the
23 determination of need assessment tool shall be eligible to
24 receive services.
25 The services shall be provided, as established by the
26 Department by rule, to eligible persons to prevent

1 unnecessary or premature institutionalization, to the
2 extent that the cost of the services, together with the
3 other personal maintenance expenses of the persons, are
4 reasonably related to the standards established for care
5 in a group facility appropriate to their condition. These
6 non-institutional services, pilot projects or experimental
7 facilities may be provided as part of or in addition to
8 those authorized by federal law or those funded and
9 administered by the Illinois Department on Aging. The
10 Department shall set rates and fees for services in a fair
11 and equitable manner. Services identical to those offered
12 by the Department on Aging shall be paid at the same rate.
13 Except as otherwise provided in this paragraph,
14 personal assistants shall be paid at a rate negotiated
15 between the State and an exclusive representative of
16 personal assistants under a collective bargaining
17 agreement. In no case shall the Department pay personal
18 assistants an hourly wage that is less than the federal
19 minimum wage. Within 30 days after July 6, 2017 (the
20 effective date of Public Act 100-23), the hourly wage paid
21 to personal assistants and individual maintenance home
22 health workers shall be increased by $0.48 per hour.
23 Solely for the purposes of coverage under the Illinois
24 Public Labor Relations Act, personal assistants providing
25 services under the Department's Home Services Program
26 shall be considered to be public employees and the State

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

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

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

26 The Department is authorized to establish a system of

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

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

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

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

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

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

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

10 (j) (Blank).

11 (k) (Blank).

12 (l) To establish, operate, and maintain a Statewide
13 Housing Clearinghouse of information on available
14 government subsidized housing accessible to persons with
15 disabilities and available privately owned housing
16 accessible to persons with disabilities. The information
17 shall include, but not be limited to, the location, rental
18 requirements, access features and proximity to public
19 transportation of available housing. The Clearinghouse
20 shall consist of at least a computerized database for the
21 storage and retrieval of information and a separate or
22 shared toll free telephone number for use by those seeking
23 information from the Clearinghouse. Department offices and
24 personnel throughout the State shall also assist in the
25 operation of the Statewide Housing Clearinghouse.
26 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; 102-826, eff. 5-13-22.)

Section 15. The Illinois Public Aid Code is amended by changing Sections 5-2b, 5-5, and 5-5.01a as follows:

(305 ILCS 5/5-2b)

Sec. 5-2b. Medically fragile and technology dependent children eligibility and program. Notwithstanding any other provision of law except as provided in Section 5-30a, on and

after September 1, 2012, subject to federal approval, medical assistance under this Article shall be available to children who qualify as persons with a disability, as defined under the federal Supplemental Security Income program and who are medically fragile and technology dependent. The program shall allow eligible children to receive the medical assistance provided under this Article in the community and must maximize, to the fullest extent permissible under federal law, federal reimbursement and family cost-sharing, including co-pays, premiums, or any other family contributions, except that the Department shall be permitted to incentivize the utilization of selected services through the use of cost-sharing adjustments. The Department shall establish the policies, procedures, standards, services, and criteria for this program by rule. Notwithstanding any other provision of law, on and after July 1, 2025, level of care eligibility criteria for home and community-based services for medically fragile and technology dependent children shall be no more restrictive than the level of care criteria in place on January 1, 2023.

(Source: P.A. 100-990, eff. 1-1-19.)

(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

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

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

22 Notwithstanding any other provision of this Section, a
23 comprehensive tobacco use cessation program that includes
24 purchasing prescription drugs or prescription medical devices
25 approved by the Food and Drug Administration shall be covered
26 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

1 Department or the MCE in which the individual is enrolled for
2 payment and shall be reimbursed at the Department's or the
3 MCE's established rates or rate methodologies for eyeglasses.
4 On and after July 1, 2012, the Department of Healthcare
5 and Family Services may provide the following services to
6 persons eligible for assistance under this Article who are
7 participating in education, training or employment programs
8 operated by the Department of Human Services as successor to
9 the Department of Public Aid:
10 (1) dental services provided by or under the
11 supervision of a dentist; and
12 (2) eyeglasses prescribed by a physician skilled in
13 the diseases of the eye, or by an optometrist, whichever
14 the person may select.
15 On and after July 1, 2018, the Department of Healthcare
16 and Family Services shall provide dental services to any adult
17 who is otherwise eligible for assistance under the medical
18 assistance program. As used in this paragraph, "dental
19 services" means diagnostic, preventative, restorative, or
20 corrective procedures, including procedures and services for
21 the prevention and treatment of periodontal disease and dental
22 caries disease, provided by an individual who is licensed to
23 practice dentistry or dental surgery or who is under the
24 supervision of a dentist in the practice of his or her
25 profession.
26 On and after July 1, 2018, targeted dental services, as

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

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

23 On and after January 1, 2022, the Department of Healthcare
24 and Family Services shall administer and regulate a
25 school-based dental program that allows for the out-of-office
26 delivery of preventative dental services in a school setting

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

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

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

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.

1 (F) A diagnostic mammogram when medically necessary,
2 as determined by a physician licensed to practice medicine
3 in all its branches, advanced practice registered nurse,
4 or physician assistant.
5 The Department shall not impose a deductible, coinsurance,
6 copayment, or any other cost-sharing requirement on the
7 coverage provided under this paragraph; except that this
8 sentence does not apply to coverage of diagnostic mammograms
9 to the extent such coverage would disqualify a high-deductible
10 health plan from eligibility for a health savings account
11 pursuant to Section 223 of the Internal Revenue Code (26
12 U.S.C. 223).
13 All screenings shall include a physical breast exam,
14 instruction on self-examination and information regarding the
15 frequency of self-examination and its value as a preventative
16 tool.
17 For purposes of this Section:
18 "Diagnostic mammogram" means a mammogram obtained using
19 diagnostic mammography.
20 "Diagnostic mammography" means a method of screening that
21 is designed to evaluate an abnormality in a breast, including
22 an abnormality seen or suspected on a screening mammogram or a
23 subjective or objective abnormality otherwise detected in the
24 breast.
25 "Low-dose mammography" means the x-ray examination of the
26 breast using equipment dedicated specifically for mammography,

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

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

10 If, at any time, the Secretary of the United States
11 Department of Health and Human Services, or its successor
12 agency, promulgates rules or regulations to be published in
13 the Federal Register or publishes a comment in the Federal
14 Register or issues an opinion, guidance, or other action that
15 would require the State, pursuant to any provision of the
16 Patient Protection and Affordable Care Act (Public Law
17 111-148), including, but not limited to, 42 U.S.C.
18 18031(d)(3)(B) or any successor provision, to defray the cost
19 of any coverage for breast tomosynthesis outlined in this
20 paragraph, then the requirement that an insurer cover breast
21 tomosynthesis is inoperative other than any such coverage
22 authorized under Section 1902 of the Social Security Act, 42
23 U.S.C. 1396a, and the State shall not assume any obligation
24 for the cost of coverage for breast tomosynthesis set forth in
25 this paragraph.

26 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 and, after January 1, 2023 (the effective date of Public Act 102-1018) ~~this amendatory Act of the 102nd General Assembly~~, breast tomosynthesis.

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

1 surgeons, oncologists, and primary care providers to establish
2 quality standards for breast cancer treatment.
3 Subject to federal approval, the Department shall
4 establish a rate methodology for mammography at federally
5 qualified health centers and other encounter-rate clinics.
6 These clinics or centers may also collaborate with other
7 hospital-based mammography facilities. By January 1, 2016, the
8 Department shall report to the General Assembly on the status
9 of the provision set forth in this paragraph.
10 The Department shall establish a methodology to remind
11 individuals who are age-appropriate for screening mammography,
12 but who have not received a mammogram within the previous 18
13 months, of the importance and benefit of screening
14 mammography. The Department shall work with experts in breast
15 cancer outreach and patient navigation to optimize these
16 reminders and shall establish a methodology for evaluating
17 their effectiveness and modifying the methodology based on the
18 evaluation.
19 The Department shall establish a performance goal for
20 primary care providers with respect to their female patients
21 over age 40 receiving an annual mammogram. This performance
22 goal shall be used to provide additional reimbursement in the
23 form of a quality performance bonus to primary care providers
24 who meet that goal.
25 The Department shall devise a means of case-managing or
26 patient navigation for beneficiaries diagnosed with breast

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

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

21 The Department shall provide coverage and reimbursement
22 for a human papillomavirus (HPV) vaccine that is approved for
23 marketing by the federal Food and Drug Administration for all
24 persons between the ages of 9 and 45 and persons of the age of
25 46 and above who have been diagnosed with cervical dysplasia
26 with a high risk of recurrence or progression. The Department

shall disallow any preauthorization requirements for the administration of the human papillomavirus (HPV) vaccine.

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

1 for other social services that may be needed by addicted
2 individuals in addition to treatment for addiction.
3 The Illinois Department, in cooperation with the
4 Departments of Human Services (as successor to the Department
5 of Alcoholism and Substance Abuse) and Public Health, through
6 a public awareness campaign, may provide information
7 concerning treatment for alcoholism and drug abuse and
8 addiction, prenatal health care, and other pertinent programs
9 directed at reducing the number of drug-affected infants born
10 to recipients of medical assistance.
11 Neither the Department of Healthcare and Family Services
12 nor the Department of Human Services shall sanction the
13 recipient solely on the basis of the recipient's substance
14 abuse.
15 The Illinois Department shall establish such regulations
16 governing the dispensing of health services under this Article
17 as it shall deem appropriate. The Department should seek the
18 advice of formal professional advisory committees appointed by
19 the Director of the Illinois Department for the purpose of
20 providing regular advice on policy and administrative matters,
21 information dissemination and educational activities for
22 medical and health care providers, and consistency in
23 procedures to the Illinois Department.
24 The Illinois Department may develop and contract with
25 Partnerships of medical providers to arrange medical services
26 for persons eligible under Section 5-2 of this Code.

1 Implementation of this Section may be by demonstration
2 projects in certain geographic areas. The Partnership shall be
3 represented by a sponsor organization. The Department, by
4 rule, shall develop qualifications for sponsors of
5 Partnerships. Nothing in this Section shall be construed to
6 require that the sponsor organization be a medical
7 organization.

8 The sponsor must negotiate formal written contracts with
9 medical providers for physician services, inpatient and
10 outpatient hospital care, home health services, treatment for
11 alcoholism and substance abuse, and other services determined
12 necessary by the Illinois Department by rule for delivery by
13 Partnerships. Physician services must include prenatal and
14 obstetrical care. The Illinois Department shall reimburse
15 medical services delivered by Partnership providers to clients
16 in target areas according to provisions of this Article and
17 the Illinois Health Finance Reform Act, except that:

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

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

26 (3) Persons receiving medical services through

1 Partnerships may receive medical and case management
2 services above the level usually offered through the
3 medical assistance program.

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

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

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

25 The Illinois Department shall require health care
26 providers to maintain records that document the medical care

1 and services provided to recipients of Medical Assistance
2 under this Article. Such records must be retained for a period
3 of not less than 6 years from the date of service or as
4 provided by applicable State law, whichever period is longer,
5 except that if an audit is initiated within the required
6 retention period then the records must be retained until the
7 audit is completed and every exception is resolved. The
8 Illinois Department shall require health care providers to
9 make available, when authorized by the patient, in writing,
10 the medical records in a timely fashion to other health care
11 providers who are treating or serving persons eligible for
12 Medical Assistance under this Article. All dispensers of
13 medical services shall be required to maintain and retain
14 business and professional records sufficient to fully and
15 accurately document the nature, scope, details and receipt of
16 the health care provided to persons eligible for medical
17 assistance under this Code, in accordance with regulations
18 promulgated by the Illinois Department. The rules and
19 regulations shall require that proof of the receipt of
20 prescription drugs, dentures, prosthetic devices and
21 eyeglasses by eligible persons under this Section accompany
22 each claim for reimbursement submitted by the dispenser of
23 such medical services. No such claims for reimbursement shall
24 be approved for payment by the Illinois Department without
25 such proof of receipt, unless the Illinois Department shall
26 have put into effect and shall be operating a system of

1 post-payment audit and review which shall, on a sampling
2 basis, be deemed adequate by the Illinois Department to assure
3 that such drugs, dentures, prosthetic devices and eyeglasses
4 for which payment is being made are actually being received by
5 eligible recipients. Within 90 days after September 16, 1984
6 (the effective date of Public Act 83-1439), the Illinois
7 Department shall establish a current list of acquisition costs
8 for all prosthetic devices and any other items recognized as
9 medical equipment and supplies reimbursable under this Article
10 and shall update such list on a quarterly basis, except that
11 the acquisition costs of all prescription drugs shall be
12 updated no less frequently than every 30 days as required by
13 Section 5-5.12.

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

25 Notwithstanding any other law to the contrary, the
26 Illinois Department shall, within 365 days after August 15,

1 2014 (the effective date of Public Act 98-963), establish
2 procedures to permit ID/DD facilities licensed under the ID/DD
3 Community Care Act and MC/DD facilities licensed under the
4 MC/DD Act to submit monthly billing claims for reimbursement
5 purposes. Following development of these procedures, the
6 Department shall have an additional 365 days to test the
7 viability of the new system and to ensure that any necessary
8 operational or structural changes to its information
9 technology platforms are implemented.

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

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

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

10 The Department has the discretion to limit the conditional
11 enrollment period for vendors based upon category of risk of
12 the vendor.

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

25 The Department shall define or specify the following: (i)
26 by provider notice, the "category of risk of the vendor" for

1 each type of vendor, which shall take into account the level of
2 screening applicable to a particular category of vendor under
3 federal law and regulations; (ii) by rule or provider notice,
4 the maximum length of the conditional enrollment period for
5 each category of risk of the vendor; and (iii) by rule, the
6 hearing rights, if any, afforded to a vendor in each category
7 of risk of the vendor that is terminated or disenrolled during
8 the conditional enrollment period.

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

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

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

26 (3) In the case of a provider for whom the Illinois

1 Department initiates the monthly billing process.
2 (4) In the case of a provider operated by a unit of
3 local government with a population exceeding 3,000,000
4 when local government funds finance federal participation
5 for claims payments.
6 For claims for services rendered during a period for which
7 a recipient received retroactive eligibility, claims must be
8 filed within 180 days after the Department determines the
9 applicant is eligible. For claims for which the Illinois
10 Department is not the primary payer, claims must be submitted
11 to the Illinois Department within 180 days after the final
12 adjudication by the primary payer.
13 In the case of long term care facilities, within 120
14 calendar days of receipt by the facility of required
15 prescreening information, new admissions with associated
16 admission documents shall be submitted through the Medical
17 Electronic Data Interchange (MEDI) or the Recipient
18 Eligibility Verification (REV) System or shall be submitted
19 directly to the Department of Human Services using required
20 admission forms. Effective September 1, 2014, admission
21 documents, including all prescreening information, must be
22 submitted through MEDI or REV. Confirmation numbers assigned
23 to an accepted transaction shall be retained by a facility to
24 verify timely submittal. Once an admission transaction has
25 been completed, all resubmitted claims following prior
26 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

1 compliance with applicable federal laws and regulations,
2 appropriate and effective methods to share such data. At a
3 minimum, and to the extent necessary to provide data sharing,
4 the Illinois Department shall enter into agreements with State
5 agencies and departments, and is authorized to enter into
6 agreements with federal agencies and departments, including,
7 but not limited to: the Secretary of State; the Department of
8 Revenue; the Department of Public Health; the Department of
9 Human Services; and the Department of Financial and
10 Professional Regulation.

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

25 The Illinois Department shall establish policies,
26 procedures, standards and criteria by rule for the

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

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

1 must meet the accreditation requirement.
2 In order to promote environmental responsibility, meet the
3 needs of recipients and enrollees, and achieve significant
4 cost savings, the Department, or a managed care organization
5 under contract with the Department, may provide recipients or
6 managed care enrollees who have a prescription or Certificate
7 of Medical Necessity access to refurbished durable medical
8 equipment under this Section (excluding prosthetic and
9 orthotic devices as defined in the Orthotics, Prosthetics, and
10 Pedorthics Practice Act and complex rehabilitation technology
11 products and associated services) through the State's
12 assistive technology program's reutilization program, using
13 staff with the Assistive Technology Professional (ATP)
14 Certification if the refurbished durable medical equipment:
15 (i) is available; (ii) is less expensive, including shipping
16 costs, than new durable medical equipment of the same type;
17 (iii) is able to withstand at least 3 years of use; (iv) is
18 cleaned, disinfected, sterilized, and safe in accordance with
19 federal Food and Drug Administration regulations and guidance
20 governing the reprocessing of medical devices in health care
21 settings; and (v) equally meets the needs of the recipient or
22 enrollee. The reutilization program shall confirm that the
23 recipient or enrollee is not already in receipt of the same or
24 similar equipment from another service provider, and that the
25 refurbished durable medical equipment equally meets the needs
26 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

1 receiving services from the long term care provider; and (iv)
2 notwithstanding any other provision of law, subject to federal
3 approval, on and after July 1, 2025, an increase in the
4 determination of need score (DON) threshold to 37 for
5 applicants for institutional long term care. In order to
6 select the minimum level of care eligibility criteria, the
7 Governor shall establish a workgroup that includes affected
8 agency representatives and stakeholders representing the
9 institutional and home and community-based long term care
10 interests. This Section shall not restrict the Department from
11 implementing lower level of care eligibility criteria for
12 community-based services in circumstances where federal
13 approval has been granted. The Department shall pursue such
14 approvals and any other measures necessary to implement
15 changes in this amendatory Act of the 103rd General Assembly.

16 Notwithstanding any other provision of this Section, on
17 and after July 1, 2025 but before July 1, 2027, continuation of
18 a nursing facility stay that began on or before June 30, 2025
19 by a person with a DON score between 29 and 36 may be covered
20 when such stay would be otherwise eligible under this Code,
21 provided the nursing facility: (i) has documented that the
22 individual was offered and declined appropriate home and
23 community-based services; (ii) documents that each month the
24 individual has been reassessed with a DON score in the
25 qualifying range; and (iii) for such individuals who at any
26 time choose to transition to community living, arranges for

1 the appropriate housing, transitional supports, and home and
2 community-based services to effectuate a successful
3 transition. The Department shall, by rule, set a maximum total
4 number of individuals to be covered under this paragraph and
5 other limits on utilization that it deems appropriate.

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

13 The Illinois Department shall report annually to the
14 General Assembly, no later than the second Friday in April of
15 1979 and each year thereafter, in regard to:

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

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

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

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

24 The period covered by each report shall be the 3 years
25 ending on the June 30 prior to the report. The report shall
26 include suggested legislation for consideration by the General

1 Assembly. The requirement for reporting to the General
2 Assembly shall be satisfied by filing copies of the report as
3 required by Section 3.1 of the General Assembly Organization
4 Act, and filing such additional copies with the State
5 Government Report Distribution Center for the General Assembly
6 as is required under paragraph (t) of Section 7 of the State
7 Library Act.

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

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

19 Because kidney transplantation can be an appropriate,
20 cost-effective alternative to renal dialysis when medically
21 necessary and notwithstanding the provisions of Section 1-11
22 of this Code, beginning October 1, 2014, the Department shall
23 cover kidney transplantation for noncitizens with end-stage
24 renal disease who are not eligible for comprehensive medical
25 benefits, who meet the residency requirements of Section 5-3
26 of this Code, and who would otherwise meet the financial

1 requirements of the appropriate class of eligible persons
2 under Section 5-2 of this Code. To qualify for coverage of
3 kidney transplantation, such person must be receiving
4 emergency renal dialysis services covered by the Department.
5 Providers under this Section shall be prior approved and
6 certified by the Department to perform kidney transplantation
7 and the services under this Section shall be limited to
8 services associated with kidney transplantation.

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

20 On or after July 1, 2015, opioid antagonists prescribed
21 for the treatment of an opioid overdose, including the
22 medication product, administration devices, and any pharmacy
23 fees or hospital fees related to the dispensing, distribution,
24 and administration of the opioid antagonist, shall be covered
25 under the medical assistance program for persons who are
26 otherwise eligible for medical assistance under this Article.

1 As used in this Section, "opioid antagonist" means a drug that
2 binds to opioid receptors and blocks or inhibits the effect of
3 opioids acting on those receptors, including, but not limited
4 to, naloxone hydrochloride or any other similarly acting drug
5 approved by the U.S. Food and Drug Administration. The
6 Department shall not impose a copayment on the coverage
7 provided for naloxone hydrochloride under the medical
8 assistance program.

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

21 A federally qualified health center, as defined in Section
22 1905(l)(2)(B) of the federal Social Security Act, shall be
23 reimbursed by the Department in accordance with the federally
24 qualified health center's encounter rate for services provided
25 to medical assistance recipients that are performed by a
26 dental hygienist, as defined under the Illinois Dental

1 Practice Act, working under the general supervision of a
2 dentist and employed by a federally qualified health center.

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

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

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

26 Notwithstanding any other provision of this Code, within

12 months after June 2, 2022 (the effective date of Public Act 102-1037) ~~this amendatory Act of the 102nd General Assembly~~ and subject to federal approval, acupuncture services performed by an acupuncturist licensed under the Acupuncture Practice Act who is acting within the scope of his or her license shall be covered under the medical assistance program. The Department shall apply for any federal waiver or State Plan amendment, if required, to implement this paragraph. The Department may adopt any rules, including standards and criteria, necessary to implement this paragraph.

(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; 102-813, eff. 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22; 102-1038 eff. 1-1-23; revised 12-14-22.)

(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.

Individuals with a score of 29 or higher based on the determination of need assessment tool shall be eligible to receive services through the program of supportive living facilities.

(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

1 Medicaid Services.

2 The Medicaid rates for supportive living facilities
3 effective on July 1, 2017 must be equal to the rates in effect
4 for supportive living facilities on June 30, 2017 increased by
5 2.8%.

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

9 Subject to federal approval, the Medicaid rates for
10 supportive living services on and after July 1, 2019 must be at
11 least 54.3% of the average total nursing facility services per
12 diem for the geographic areas defined by the Department while
13 maintaining the rate differential for dementia care and must
14 be updated whenever the total nursing facility service per
15 diems are updated. Beginning July 1, 2022, upon the
16 implementation of the Patient Driven Payment Model, Medicaid
17 rates for supportive living services must be at least 54.3% of
18 the average total nursing services per diem rate for the
19 geographic areas. For purposes of this provision, the average
20 total nursing services per diem rate shall include all add-ons
21 for nursing facilities for the geographic area provided for in
22 Section 5-5.2. The rate differential for dementia care must be
23 maintained in these rates and the rates shall be updated
24 whenever nursing facility per diem rates are updated.

25 (c) The Department may adopt rules to implement this
26 Section. Rules that establish or modify the services,

1 standards, and conditions for participation in the program
2 shall be adopted by the Department in consultation with the
3 Department on Aging, the Department of Rehabilitation
4 Services, and the Department of Mental Health and
5 Developmental Disabilities (or their successor agencies).
6 (d) Subject to federal approval by the Centers for
7 Medicare and Medicaid Services, the Department shall accept
8 for consideration of certification under the program any
9 application for a site or building where distinct parts of the
10 site or building are designated for purposes other than the
11 provision of supportive living services, but only if:
12 (1) those distinct parts of the site or building are
13 not designated for the purpose of providing assisted
14 living services as required under the Assisted Living and
15 Shared Housing Act;
16 (2) those distinct parts of the site or building are
17 completely separate from the part of the building used for
18 the provision of supportive living program services,
19 including separate entrances;
20 (3) those distinct parts of the site or building do
21 not share any common spaces with the part of the building
22 used for the provision of supportive living program
23 services; and
24 (4) those distinct parts of the site or building do
25 not share staffing with the part of the building used for
26 the provision of supportive living program services.

1 (e) Facilities or distinct parts of facilities which are
2 selected as supportive living facilities and are in good
3 standing with the Department's rules are exempt from the
4 provisions of the Nursing Home Care Act and the Illinois
5 Health Facilities Planning Act.
6 (f) Section 9817 of the American Rescue Plan Act of 2021
7 (Public Law 117-2) authorizes a 10% enhanced federal medical
8 assistance percentage for supportive living services for a
9 12-month period from April 1, 2021 through March 31, 2022.
10 Subject to federal approval, including the approval of any
11 necessary waiver amendments or other federally required
12 documents or assurances, for a 12-month period the Department
13 must pay a supplemental $26 per diem rate to all supportive
14 living facilities with the additional federal financial
15 participation funds that result from the enhanced federal
16 medical assistance percentage from April 1, 2021 through March
17 31, 2022. The Department may issue parameters around how the
18 supplemental payment should be spent, including quality
19 improvement activities. The Department may alter the form,
20 methods, or timeframes concerning the supplemental per diem
21 rate to comply with any subsequent changes to federal law,
22 changes made by guidance issued by the federal Centers for
23 Medicare and Medicaid Services, or other changes necessary to
24 receive the enhanced federal medical assistance percentage.
25 (Source: P.A. 101-10, eff. 6-5-19; 102-43, eff. 7-6-21;
26 102-699, eff. 4-19-22.)

1 Section 99. Effective date. This Act takes effect July 1,
2 2025.