Rep. Sara Feigenholtz

Filed: 5/27/2011

AMENDMENT TO SENATE BILL 1802

AMENDMENT NO. _____. Amend Senate Bill 1802 by replacing everything after the enacting clause with the following:

"Section 1. The Department of Human Services Act is amended by adding Section 10-66 as follows:

(20 ILCS 1305/10-66 new)

Sec. 10-66. Rate reductions. For State fiscal year 2012, rates for medical services purchased by the Divisions of Alcohol and Substance Abuse, Community Health and Prevention, Developmentally Disabilities, Mental Health, or Rehabilitation Services within the Department of Human Services shall not be reduced below the rates calculated on April 1, 2011 unless the Department of Human Services promulgates rules and rules are implemented authorizing rate reductions.

Section 3. The Disabled Persons Rehabilitation Act is

amended by adding Section 10a as follows:

(20 ILCS 2405/10a new)

Sec. 10a. Financial Participation of Students Attending the Illinois School for the Deaf and the Illinois School for the Visually Impaired.

(a) General. The Illinois School for the Deaf and the Illinois School for the Visually Impaired are required to provide eligible students with disabilities with a free and appropriate education. As part of the admission process to either school, the Department shall complete a financial analysis on each student attending the Illinois School for the Deaf or the Illinois School for the Visually Impaired and shall ask parents or guardians to participate, if applicable, in the cost of identified services or activities that are not education related.

(b) Completion of financial analysis. Prior to admission, and annually thereafter, a financial analysis shall be completed on each student attending the Illinois School for the Deaf or the Illinois School for the Visually Impaired. If at any time there is reason to believe there is a change in the student's financial situation that will affect their financial participation, a new financial analysis shall be completed.

(1) In completing the student's financial analysis, the income of the student's family shall be used. Proof of income must be provided and retained for each parent or

guardian.

(2) Any funds that have been established on behalf of the student for completion of their primary or secondary education shall be considered when completing the financial analysis.

(3) Falsification of information used to complete the financial analysis may result in the Department taking action to recoup monies previously expended by the Department in providing services to the student.

(c) Financial Participation. Utilizing a sliding scale based on income standards developed by the Department, parents or guardians of students attending the Illinois School for the Deaf or the Illinois School for the Visually Impaired shall be asked to financially participate in the following fees for services or activities provided at the schools:

(1) Registration.

(2) Books, labs, and supplies (fees may vary depending on the classes in which a student participates).

(3) Room and board for residential students.

(4) Meals for day students.

(5) Athletic or extracurricular activities (students participating in multiple activities will not be required to pay for more than 2 activities).

(6) Driver's education (if applicable).

(7) Graduation.

(8) Yearbook (optional).

(9) Activities (field trips or other leisure activities).

(10) Other activities or services identified by the Department.

Students, parents, or guardians who are receiving Medicaid or Temporary Assistance for Needy Families (TANF) shall not be required to financially participate in the fees established in this subsection (c).

Exceptions may be granted to parents or guardians who are unable to meet the financial participation obligations due to extenuating circumstances. Requests for exceptions must be made in writing and must be submitted to the Director of the Division of Rehabilitation Services for review.

Section 5. The State Prompt Payment Act is amended by changing Section 3-2 as follows:

(30 ILCS 540/3-2)

Sec. 3-2. Beginning July 1, 1993, in any instance where a State official or agency is late in payment of a vendor's bill or invoice for goods or services furnished to the State, as defined in Section 1, properly approved in accordance with rules promulgated under Section 3-3, the State official or agency shall pay interest to the vendor in accordance with the following:

(1) Any bill~~, except a bill submitted under Article V~~

~~of the Illinois Public Aid Code,~~ approved for payment under this Section must be paid or the payment issued to the payee within 90 ~~60~~ days of receipt of a proper bill or invoice. If payment is not issued to the payee within this 90-day ~~60 day~~ period, an interest penalty of 1.0% of any amount approved and unpaid shall be added for each month or fraction thereof after the end of this 90-day ~~60 day~~ period, until final payment is made. ~~Any bill, except a bill for pharmacy or nursing facility services or goods, submitted under Article V of the Illinois Public Aid Code approved for payment under this Section must be paid or the payment issued to the payee within 60 days after receipt of a proper bill or invoice, and, if payment is not issued to the payee within this 60 day period, an interest penalty of 2.0% of any amount approved and unpaid shall be added for each month or fraction thereof after the end of this 60 day period, until final payment is made. Any bill for pharmacy or nursing facility services or goods submitted under Article V of the Illinois Public Aid Code, approved for payment under this Section must be paid or the payment issued to the payee within 60 days of receipt of a proper bill or invoice. If payment is not issued to the payee within this 60-day 60 day period, an interest penalty of 1.0% of any amount approved and unpaid shall be added for each month or fraction thereof after the end of this 60 day 60 day period, until final payment is made.~~

(1.1) A State agency shall review in a timely manner each bill or invoice after its receipt. If the State agency determines that the bill or invoice contains a defect making it unable to process the payment request, the agency shall notify the vendor requesting payment as soon as possible after discovering the defect pursuant to rules promulgated under Section 3-3; provided, however, that the notice for construction related bills or invoices must be given not later than 30 days after the bill or invoice was first submitted. The notice shall identify the defect and any additional information necessary to correct the defect. If one or more items on a construction related bill or invoice are disapproved, but not the entire bill or invoice, then the portion that is not disapproved shall be paid.

(2) Where a State official or agency is late in payment of a vendor's bill or invoice properly approved in accordance with this Act, and different late payment terms are not reduced to writing as a contractual agreement, the State official or agency shall automatically pay interest penalties required by this Section amounting to $50 or more to the appropriate vendor. Each agency shall be responsible for determining whether an interest penalty is owed and for paying the interest to the vendor. Interest due to a vendor that amounts to less than $50 shall not be paid but shall be accrued until all interest due the vendor for all

similar warrants exceeds $50, at which time the accrued interest shall be payable and interest will begin accruing again, except that interest accrued as of the end of the fiscal year that does not exceed $50 shall be payable at that time. In the event an individual has paid a vendor for services in advance, the provisions of this Section shall apply until payment is made to that individual.

(3) The provisions of Public Act 96-1501 ~~this amendatory Act of the 96th General Assembly~~ reducing the interest rate on pharmacy claims under Article V of the Illinois Public Aid Code to 1.0% per month shall apply to any pharmacy bills for services and goods under Article V of the Illinois Public Aid Code received on or after the date 60 days before January 25, 2011 (the effective date of Public Act 96-1501) until the effective date of this amendatory Act of the 97th General Assembly ~~this amendatory Act of the 96th General Assembly~~.

(Source: P.A. 96-555, eff. 8-18-09; 96-802, eff. 1-1-10; 96-959, eff. 7-1-10; 96-1000, eff. 7-2-10; 96-1501, eff. 1-25-11; 96-1530, eff. 2-16-11; revised 2-22-11.)

Section 10. The Children's Health Insurance Program Act is amended by changing Section 30 as follows:

(215 ILCS 106/30)

Sec. 30. Cost sharing.

(a) Children enrolled in a health benefits program pursuant to subdivision (a)(2) of Section 25 and persons enrolled in a health benefits waiver program pursuant to Section 40 shall be subject to the following cost sharing requirements:

(1) There shall be no co-payment required for well-baby or well-child care, including age-appropriate immunizations as required under federal law.

(2) Health insurance premiums for family members, either children or adults, in families whose household income is above 150% of the federal poverty level shall be payable monthly, subject to rules promulgated by the Department for grace periods and advance payments, and shall be as follows:

(A) $15 per month for one family member.

(B) $25 per month for 2 family members.

(C) $30 per month for 3 family members.

(D) $35 per month for 4 family members.

(E) $40 per month for 5 or more family members.

(3) Co-payments for children or adults in families whose income is at or below 150% of the federal poverty level, at a minimum and to the extent permitted under federal law, shall be $2 for all medical visits and prescriptions provided under this Act <u>and up to $10 for emergency room use for a non-emergency situation as defined by the Department by rule and subject to federal approval</u>.

(4) Co-payments for children or adults in families

whose income is above 150% of the federal poverty level, at a minimum and to the extent permitted under federal law shall be as follows:

(A) $5 for medical visits.

(B) $3 for generic prescriptions and $5 for brand name prescriptions.

(C) $25 for emergency room use for a non-emergency situation as defined by the Department by rule.

(5) (Blank) ~~The maximum amount of out-of-pocket expenses for co-payments shall be $100 per family per year~~.

(6) Co-payments shall be maximized to the extent permitted by federal law and are subject to federal approval.

(b) Individuals enrolled in a privately sponsored health insurance plan pursuant to subdivision (a)(1) of Section 25 shall be subject to the cost sharing provisions as stated in the privately sponsored health insurance plan.

(Source: P.A. 94-48, eff. 7-1-05.)

Section 15. The Illinois Public Aid Code is amended by changing Sections 5-2, 5-4.1, 5-5.12, 5A-10, 14-8, as follows:

(305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

Sec. 5-2. Classes of Persons Eligible. Medical assistance under this Article shall be available to any of the following classes of persons in respect to whom a plan for coverage has

been submitted to the Governor by the Illinois Department and approved by him:

1. Recipients of basic maintenance grants under Articles III and IV.

2. Persons otherwise eligible for basic maintenance under Articles III and IV, excluding any eligibility requirements that are inconsistent with any federal law or federal regulation, as interpreted by the U.S. Department of Health and Human Services, but who fail to qualify thereunder on the basis of need or who qualify but are not receiving basic maintenance under Article IV, and who have insufficient income and resources to meet the costs of necessary medical care, including but not limited to the following:

(a) All persons otherwise eligible for basic maintenance under Article III but who fail to qualify under that Article on the basis of need and who meet either of the following requirements:

(i) their income, as determined by the Illinois Department in accordance with any federal requirements, is equal to or less than 70% in fiscal year 2001, equal to or less than 85% in fiscal year 2002 and until a date to be determined by the Department by rule, and equal to or less than 100% beginning on the date determined by the Department by rule, of the nonfarm income official

poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the same size; or

(ii) their income, after the deduction of costs incurred for medical care and for other types of remedial care, is equal to or less than 70% in fiscal year 2001, equal to or less than 85% in fiscal year 2002 and until a date to be determined by the Department by rule, and equal to or less than 100% beginning on the date determined by the Department by rule, of the nonfarm income official poverty line, as defined in item (i) of this subparagraph (a).

(b) All persons who, excluding any eligibility requirements that are inconsistent with any federal law or federal regulation, as interpreted by the U.S. Department of Health and Human Services, would be determined eligible for such basic maintenance under Article IV by disregarding the maximum earned income permitted by federal law.

3. Persons who would otherwise qualify for Aid to the Medically Indigent under Article VII.

4. Persons not eligible under any of the preceding paragraphs who fall sick, are injured, or die, not having

sufficient money, property or other resources to meet the costs of necessary medical care or funeral and burial expenses.

5.(a) Women during pregnancy, after the fact of pregnancy has been determined by medical diagnosis, and during the 60-day period beginning on the last day of the pregnancy, together with their infants and children born after September 30, 1983, whose income and resources are insufficient to meet the costs of necessary medical care to the maximum extent possible under Title XIX of the Federal Social Security Act.

(b) The Illinois Department and the Governor shall provide a plan for coverage of the persons eligible under paragraph 5(a) by April 1, 1990. Such plan shall provide ambulatory prenatal care to pregnant women during a presumptive eligibility period and establish an income eligibility standard that is equal to 133% of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the same size, provided that costs incurred for medical care are not taken into account in determining such income eligibility.

(c) The Illinois Department may conduct a demonstration in at least one county that will provide

medical assistance to pregnant women, together with their infants and children up to one year of age, where the income eligibility standard is set up to 185% of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget. The Illinois Department shall seek and obtain necessary authorization provided under federal law to implement such a demonstration. Such demonstration may establish resource standards that are not more restrictive than those established under Article IV of this Code.

6. Persons under the age of 18 who fail to qualify as dependent under Article IV and who have insufficient income and resources to meet the costs of necessary medical care to the maximum extent permitted under Title XIX of the Federal Social Security Act.

7. Persons who are under 21 years of age and would qualify as disabled as defined under the Federal Supplemental Security Income Program, provided medical service for such persons would be eligible for Federal Financial Participation, and provided the Illinois Department determines that:

(a) the person requires a level of care provided by a hospital, skilled nursing facility, or intermediate care facility, as determined by a physician licensed to practice medicine in all its branches;

(b) it is appropriate to provide such care outside

of an institution, as determined by a physician licensed to practice medicine in all its branches;

(c) the estimated amount which would be expended for care outside the institution is not greater than the estimated amount which would be expended in an institution.

8. Persons who become ineligible for basic maintenance assistance under Article IV of this Code in programs administered by the Illinois Department due to employment earnings and persons in assistance units comprised of adults and children who become ineligible for basic maintenance assistance under Article VI of this Code due to employment earnings. The plan for coverage for this class of persons shall:

(a) extend the medical assistance coverage for up to 12 months following termination of basic maintenance assistance; and

(b) offer persons who have initially received 6 months of the coverage provided in paragraph (a) above, the option of receiving an additional 6 months of coverage, subject to the following:

(i) such coverage shall be pursuant to provisions of the federal Social Security Act;

(ii) such coverage shall include all services covered while the person was eligible for basic maintenance assistance;

(iii) no premium shall be charged for such coverage; and

(iv) such coverage shall be suspended in the event of a person's failure without good cause to file in a timely fashion reports required for this coverage under the Social Security Act and coverage shall be reinstated upon the filing of such reports if the person remains otherwise eligible.

9. Persons with acquired immunodeficiency syndrome (AIDS) or with AIDS-related conditions with respect to whom there has been a determination that but for home or community-based services such individuals would require the level of care provided in an inpatient hospital, skilled nursing facility or intermediate care facility the cost of which is reimbursed under this Article. Assistance shall be provided to such persons to the maximum extent permitted under Title XIX of the Federal Social Security Act.

10. Participants in the long-term care insurance partnership program established under the Illinois Long-Term Care Partnership Program Act who meet the qualifications for protection of resources described in Section 15 of that Act.

11. Persons with disabilities who are employed and eligible for Medicaid, pursuant to Section

1902(a)(10)(A)(ii)(xv) of the Social Security Act, and, subject to federal approval, persons with a medically improved disability who are employed and eligible for Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of the Social Security Act, as provided by the Illinois Department by rule. In establishing eligibility standards under this paragraph 11, the Department shall, subject to federal approval:

(a) set the income eligibility standard at not lower than 350% of the federal poverty level;

(b) exempt retirement accounts that the person cannot access without penalty before the age of 59 1/2, and medical savings accounts established pursuant to 26 U.S.C. 220;

(c) allow non-exempt assets up to $25,000 as to those assets accumulated during periods of eligibility under this paragraph 11; and

(d) continue to apply subparagraphs (b) and (c) in determining the eligibility of the person under this Article even if the person loses eligibility under this paragraph 11.

12. Subject to federal approval, persons who are eligible for medical assistance coverage under applicable provisions of the federal Social Security Act and the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000. Those eligible persons are defined

to include, but not be limited to, the following persons:

(1) persons who have been screened for breast or cervical cancer under the U.S. Centers for Disease Control and Prevention Breast and Cervical Cancer Program established under Title XV of the federal Public Health Services Act in accordance with the requirements of Section 1504 of that Act as administered by the Illinois Department of Public Health; and

(2) persons whose screenings under the above program were funded in whole or in part by funds appropriated to the Illinois Department of Public Health for breast or cervical cancer screening.

"Medical assistance" under this paragraph 12 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. The Department must request federal approval of the coverage under this paragraph 12 within 30 days after the effective date of this amendatory Act of the 92nd General Assembly.

In addition to the persons who are eligible for medical assistance pursuant to subparagraphs (1) and (2) of this paragraph 12, and to be paid from funds appropriated to the Department for its medical programs, any uninsured person as defined by the Department in rules residing in Illinois who is younger than 65 years of age, who has been screened

for breast and cervical cancer in accordance with standards and procedures adopted by the Department of Public Health for screening, and who is referred to the Department by the Department of Public Health as being in need of treatment for breast or cervical cancer is eligible for medical assistance benefits that are consistent with the benefits provided to those persons described in subparagraphs (1) and (2). Medical assistance coverage for the persons who are eligible under the preceding sentence is not dependent on federal approval, but federal moneys may be used to pay for services provided under that coverage upon federal approval.

13. Subject to appropriation and to federal approval, persons living with HIV/AIDS who are not otherwise eligible under this Article and who qualify for services covered under Section 5-5.04 as provided by the Illinois Department by rule.

14. Subject to the availability of funds for this purpose, the Department may provide coverage under this Article to persons who reside in Illinois who are not eligible under any of the preceding paragraphs and who meet the income guidelines of paragraph 2(a) of this Section and (i) have an application for asylum pending before the federal Department of Homeland Security or on appeal before a court of competent jurisdiction and are represented either by counsel or by an advocate accredited by the

federal Department of Homeland Security and employed by a not-for-profit organization in regard to that application or appeal, or (ii) are receiving services through a federally funded torture treatment center. Medical coverage under this paragraph 14 may be provided for up to 24 continuous months from the initial eligibility date so long as an individual continues to satisfy the criteria of this paragraph 14. If an individual has an appeal pending regarding an application for asylum before the Department of Homeland Security, eligibility under this paragraph 14 may be extended until a final decision is rendered on the appeal. The Department may adopt rules governing the implementation of this paragraph 14.

15. Family Care Eligibility.

(a) Through December 31, 2013, a ~~A~~ caretaker relative who is 19 years of age or older when countable income is at or below 185% of the Federal Poverty Level Guidelines, as published annually in the Federal Register, for the appropriate family size. Beginning January 1, 2014, a caretaker relative who is 19 years of age or older when countable income is at or below 133% of the Federal Poverty Level Guidelines, as published annually in the Federal Register, for the appropriate family size. A person may not spend down to become eligible under this paragraph 15.

(b) Eligibility shall be reviewed annually.

(c) Caretaker relatives enrolled under this paragraph 15 in families with countable income above 150% and at or below 185% of the Federal Poverty Level Guidelines shall be counted as family members and pay premiums as established under the Children's Health Insurance Program Act.

(d) Premiums shall be billed by and payable to the Department or its authorized agent, on a monthly basis.

(e) The premium due date is the last day of the month preceding the month of coverage.

(f) Individuals shall have a grace period through 30 days of coverage to pay the premium.

(g) Failure to pay the full monthly premium by the last day of the grace period shall result in termination of coverage.

(h) Partial premium payments shall not be refunded.

(i) Following termination of an individual's coverage under this paragraph 15, the following action is required before the individual can be re-enrolled:

(1) A new application must be completed and the individual must be determined otherwise eligible.

(2) There must be full payment of premiums due under this Code, the Children's Health Insurance Program Act, the Covering ALL KIDS Health Insurance Act, or any other healthcare program

administered by the Department for periods in which a premium was owed and not paid for the individual.

(3) The first month's premium must be paid if there was an unpaid premium on the date the individual's previous coverage was canceled.

The Department is authorized to implement the provisions of this amendatory Act of the 95th General Assembly by adopting the medical assistance rules in effect as of October 1, 2007, at 89 Ill. Admin. Code 125, and at 89 Ill. Admin. Code 120.32 along with only those changes necessary to conform to federal Medicaid requirements, federal laws, and federal regulations, including but not limited to Section 1931 of the Social Security Act (42 U.S.C. Sec. 1396u-1), as interpreted by the U.S. Department of Health and Human Services, and the countable income eligibility standard authorized by this paragraph 15. The Department may not otherwise adopt any rule to implement this increase except as authorized by law, to meet the eligibility standards authorized by the federal government in the Medicaid State Plan or the Title XXI Plan, or to meet an order from the federal government or any court.

16. Subject to appropriation, uninsured persons who are not otherwise eligible under this Section who have been certified and referred by the Department of Public Health as having been screened and found to need diagnostic

evaluation or treatment, or both diagnostic evaluation and treatment, for prostate or testicular cancer. For the purposes of this paragraph 16, uninsured persons are those who do not have creditable coverage, as defined under the Health Insurance Portability and Accountability Act, or have otherwise exhausted any insurance benefits they may have had, for prostate or testicular cancer diagnostic evaluation or treatment, or both diagnostic evaluation and treatment. To be eligible, a person must furnish a Social Security number. A person's assets are exempt from consideration in determining eligibility under this paragraph 16. Such persons shall be eligible for medical assistance under this paragraph 16 for so long as they need treatment for the cancer. A person shall be considered to need treatment if, in the opinion of the person's treating physician, the person requires therapy directed toward cure or palliation of prostate or testicular cancer, including recurrent metastatic cancer that is a known or presumed complication of prostate or testicular cancer and complications resulting from the treatment modalities themselves. Persons who require only routine monitoring services are not considered to need treatment. "Medical assistance" under this paragraph 16 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. Notwithstanding any other provision of law, the Department (i) does not have a

claim against the estate of a deceased recipient of services under this paragraph 16 and (ii) does not have a lien against any homestead property or other legal or equitable real property interest owned by a recipient of services under this paragraph 16.

In implementing the provisions of Public Act 96-20, the Department is authorized to adopt only those rules necessary, including emergency rules. Nothing in Public Act 96-20 permits the Department to adopt rules or issue a decision that expands eligibility for the FamilyCare Program to a person whose income exceeds 185% of the Federal Poverty Level as determined from time to time by the U.S. Department of Health and Human Services, unless the Department is provided with express statutory authority.

The Illinois Department and the Governor shall provide a plan for coverage of the persons eligible under paragraph 7 as soon as possible after July 1, 1984.

The eligibility of any such person for medical assistance under this Article is not affected by the payment of any grant under the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act. The Department shall by rule establish the amounts of assets to be disregarded in determining eligibility for medical assistance, which shall at a minimum equal the

amounts to be disregarded under the Federal Supplemental Security Income Program. The amount of assets of a single person to be disregarded shall not be less than $2,000, and the amount of assets of a married couple to be disregarded shall not be less than $3,000.

To the extent permitted under federal law, any person found guilty of a second violation of Article VIIIA shall be ineligible for medical assistance under this Article, as provided in Section 8A-8.

The eligibility of any person for medical assistance under this Article shall not be affected by the receipt by the person of donations or benefits from fundraisers held for the person in cases of serious illness, as long as neither the person nor members of the person's family have actual control over the donations or benefits or the disbursement of the donations or benefits.

(Source: P.A. 95-546, eff. 8-29-07; 95-1055, eff. 4-10-09; 96-20, eff. 6-30-09; 96-181, eff. 8-10-09; 96-328, eff. 8-11-09; 96-567, eff. 1-1-10; 96-1000, eff. 7-2-10; 96-1123, eff. 1-1-11; 96-1270, eff. 7-26-10; revised 9-16-10.)

(305 ILCS 5/5-4.1) (from Ch. 23, par. 5-4.1)

Sec. 5-4.1. Co-payments. The Department may by rule provide that recipients under any Article of this Code shall pay a fee as a co-payment for services. Co-payments shall be maximized to the extent permitted by federal law. Provided, however, that

any such rule must provide that no co-payment requirement can exist for renal dialysis, radiation therapy, cancer chemotherapy, or insulin, and other products necessary on a recurring basis, the absence of which would be life threatening, or where co-payment expenditures for required services and/or medications for chronic diseases that the Illinois Department shall by rule designate shall cause an extensive financial burden on the recipient, and provided no co-payment shall exist for emergency room encounters which are for medical emergencies. The Department shall seek approval of a State plan amendment that allows pharmacies to refuse to dispense drugs in circumstances where the recipient does not pay the required co-payment. In the event the State plan amendment is rejected, co-payments may not exceed $3 for brand name drugs, $1 for other pharmacy services other than for generic drugs, and $2 for physician services, dental services, optical services and supplies, chiropractic services, podiatry services, and encounter rate clinic services. There shall be no co-payment for generic drugs. Co-payments may not exceed $10 for emergency room use for a non-emergency situation as defined by the Department by rule and subject to federal approval. ~~Co-payments may not exceed $3 for hospital outpatient and clinic services.~~

(Source: P.A. 96-1501, eff. 1-25-11.)

(305 ILCS 5/5-5.12) (from Ch. 23, par. 5-5.12)

Sec. 5-5.12. Pharmacy payments.

(a) Every request submitted by a pharmacy for reimbursement under this Article for prescription drugs provided to a recipient of aid under this Article shall include the name of the prescriber or an acceptable identification number as established by the Department.

(b) Pharmacies providing prescription drugs under this Article shall be reimbursed at a rate which shall include a professional dispensing fee as determined by the Illinois Department, plus the current acquisition cost of the prescription drug dispensed. The Illinois Department shall update its information on the acquisition costs of all prescription drugs no less frequently than every 30 days. However, the Illinois Department may set the rate of reimbursement for the acquisition cost, by rule, at a percentage of the current average wholesale acquisition cost.

(c) (Blank).

(d) The Department shall not impose requirements for prior approval based on a preferred drug list for anti-retroviral, anti-hemophilic factor concentrates, or any atypical antipsychotics, conventional antipsychotics, or anticonvulsants used for the treatment of serious mental illnesses until 30 days after it has conducted a study of the impact of such requirements on patient care and submitted a report to the Speaker of the House of Representatives and the President of the Senate. The Department shall review

utilization of narcotic medications in the medical assistance program and impose utilization controls that protect against abuse.

(e) When making determinations as to which drugs shall be on a prior approval list, the Department shall include as part of the analysis for this determination, the degree to which a drug may affect individuals in different ways based on factors including the gender of the person taking the medication.

(f) The Department shall cooperate with the Department of Public Health and the Department of Human Services Division of Mental Health in identifying psychotropic medications that, when given in a particular form, manner, duration, or frequency (including "as needed") in a dosage, or in conjunction with other psychotropic medications to a nursing home resident, may constitute a chemical restraint or an "unnecessary drug" as defined by the Nursing Home Care Act or Titles XVIII and XIX of the Social Security Act and the implementing rules and regulations. The Department shall require prior approval for any such medication prescribed for a nursing home resident that appears to be a chemical restraint or an unnecessary drug. The Department shall consult with the Department of Human Services Division of Mental Health in developing a protocol and criteria for deciding whether to grant such prior approval.

(g) The Department may by rule provide for reimbursement of the dispensing of a 90-day supply of a generic, non-narcotic maintenance medication in circumstances where it is cost

effective.

(h) Effective July 1, 2011, the Department shall discontinue coverage of select over-the-counter drugs, including analgesics and cough and cold and allergy medications.

(i) The Department shall seek any necessary waiver from the federal government in order to establish a program limiting the pharmacies eligible to dispense specialty drugs and shall issue a Request for Proposals in order to maximize savings on these drugs. The Department shall by rule establish the drugs required to be dispensed in this program.

(Source: P.A. 96-1269, eff. 7-26-10; 96-1372, eff. 7-29-10; 96-1501, eff. 1-25-11.)

(305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

Sec. 5A-10. Applicability.

(a) The assessment imposed by Section 5A-2 shall not take effect or shall cease to be imposed, and any moneys remaining in the Fund shall be refunded to hospital providers in proportion to the amounts paid by them, if:

(1) The sum of the appropriations for State fiscal years 2004 and 2005 from the General Revenue Fund for hospital payments under the medical assistance program is less than $4,500,000,000 or the appropriation for each of State fiscal years 2006, 2007 and 2008 from the General Revenue Fund for hospital payments under the medical

assistance program is less than $2,500,000,000 increased annually to reflect any increase in the number of recipients, or the annual appropriation for State fiscal years 2009, 2010, 2011, 2013, and 2014 ~~through 2014~~, from the General Revenue Fund combined with the Hospital Provider Fund as authorized in Section 5A-8 for hospital payments under the medical assistance program, is less than the amount appropriated for State fiscal year 2009, adjusted annually to reflect any change in the number of recipients, excluding State fiscal year 2009 supplemental appropriations made necessary by the enactment of the American Recovery and Reinvestment Act of 2009; or

(2) For State fiscal years prior to State fiscal year 2009, the Department of Healthcare and Family Services (formerly Department of Public Aid) makes changes in its rules that reduce the hospital inpatient or outpatient payment rates, including adjustment payment rates, in effect on October 1, 2004, except for hospitals described in subsection (b) of Section 5A-3 and except for changes in the methodology for calculating outlier payments to hospitals for exceptionally costly stays, so long as those changes do not reduce aggregate expenditures below the amount expended in State fiscal year 2005 for such services; or

(2.1) For State fiscal years 2009, 2010, 2011, 2013, and 2014 ~~through 2014~~, the Department of Healthcare and

Family Services adopts any administrative rule change to reduce payment rates or alters any payment methodology that reduces any payment rates made to operating hospitals under the approved Title XIX or Title XXI State plan in effect January 1, 2008 except for:

(A) any changes for hospitals described in subsection (b) of Section 5A-3; or

(B) any rates for payments made under this Article V-A; or

(C) any changes proposed in State plan amendment transmittal numbers 08-01, 08-02, 08-04, 08-06, and 08-07; or

(D) in relation to any admissions on or after January 1, 2011, a modification in the methodology for calculating outlier payments to hospitals for exceptionally costly stays, for hospitals reimbursed under the diagnosis-related grouping methodology; provided that the Department shall be limited to one such modification during the 36-month period after the effective date of this amendatory Act of the 96th General Assembly; or

(E) changes in hospital payment rates related to potentially preventable readmissions as described in Section 14-8 of this Code; or

(3) The payments to hospitals required under Section 5A-12 or Section 5A-12.2 are changed or are not eligible

for federal matching funds under Title XIX or XXI of the Social Security Act.

(b) The assessment imposed by Section 5A-2 shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax under Title XIX of the Social Security Act. Moneys in the Hospital Provider Fund derived from assessments imposed prior thereto shall be disbursed in accordance with Section 5A-8 to the extent federal financial participation is not reduced due to the impermissibility of the assessments, and any remaining moneys shall be refunded to hospital providers in proportion to the amounts paid by them.

(Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08; 96-8, eff. 4-28-09; 96-1530, eff. 2-16-11.)

(305 ILCS 5/14-8) (from Ch. 23, par. 14-8)

Sec. 14-8. Disbursements to Hospitals.

(a) For inpatient hospital services rendered on and after September 1, 1991, the Illinois Department shall reimburse hospitals for inpatient services at an inpatient payment rate calculated for each hospital based upon the Medicare Prospective Payment System as set forth in Sections 1886(b), (d), (g), and (h) of the federal Social Security Act, and the regulations, policies, and procedures promulgated thereunder, except as modified by this Section. Payment rates for inpatient hospital services rendered on or after September 1, 1991 and on

or before September 30, 1992 shall be calculated using the Medicare Prospective Payment rates in effect on September 1, 1991. Payment rates for inpatient hospital services rendered on or after October 1, 1992 and on or before March 31, 1994 shall be calculated using the Medicare Prospective Payment rates in effect on September 1, 1992. Payment rates for inpatient hospital services rendered on or after April 1, 1994 shall be calculated using the Medicare Prospective Payment rates (including the Medicare grouping methodology and weighting factors as adjusted pursuant to paragraph (1) of this subsection) in effect 90 days prior to the date of admission. For services rendered on or after July 1, 1995, the reimbursement methodology implemented under this subsection shall not include those costs referred to in Sections 1886(d)(5)(B) and 1886(h) of the Social Security Act. The additional payment amounts required under Section 1886(d)(5)(F) of the Social Security Act, for hospitals serving a disproportionate share of low-income or indigent patients, are not required under this Section. For hospital inpatient services rendered on or after July 1, 1995, the Illinois Department shall reimburse hospitals using the relative weighting factors and the base payment rates calculated for each hospital that were in effect on June 30, 1995, less the portion of such rates attributed by the Illinois Department to the cost of medical education.

(1) The weighting factors established under Section

1886(d)(4) of the Social Security Act shall not be used in the reimbursement system established under this Section. Rather, the Illinois Department shall establish by rule Medicaid weighting factors to be used in the reimbursement system established under this Section.

(2) The Illinois Department shall define by rule those hospitals or distinct parts of hospitals that shall be exempt from the reimbursement system established under this Section. In defining such hospitals, the Illinois Department shall take into consideration those hospitals exempt from the Medicare Prospective Payment System as of September 1, 1991. For hospitals defined as exempt under this subsection, the Illinois Department shall by rule establish a reimbursement system for payment of inpatient hospital services rendered on and after September 1, 1991. For all hospitals that are children's hospitals as defined in Section 5-5.02 of this Code, the reimbursement methodology shall, through June 30, 1992, net of all applicable fees, at least equal each children's hospital 1990 ICARE payment rates, indexed to the current year by application of the DRI hospital cost index from 1989 to the year in which payments are made. Excepting county providers as defined in Article XV of this Code, hospitals licensed under the University of Illinois Hospital Act, and facilities operated by the Department of Mental Health and Developmental Disabilities (or its successor, the

Department of Human Services) for hospital inpatient services rendered on or after July 1, 1995, the Illinois Department shall reimburse children's hospitals, as defined in 89 Illinois Administrative Code Section 149.50(c)(3), at the rates in effect on June 30, 1995, and shall reimburse all other hospitals at the rates in effect on June 30, 1995, less the portion of such rates attributed by the Illinois Department to the cost of medical education. For inpatient hospital services provided on or after August 1, 1998, the Illinois Department may establish by rule a means of adjusting the rates of children's hospitals, as defined in 89 Illinois Administrative Code Section 149.50(c)(3), that did not meet that definition on June 30, 1995, in order for the inpatient hospital rates of such hospitals to take into account the average inpatient hospital rates of those children's hospitals that did meet the definition of children's hospitals on June 30, 1995.

(3) (Blank)

(4) Notwithstanding any other provision of this Section, hospitals that on August 31, 1991, have a contract with the Illinois Department under Section 3-4 of the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care.

(5) In addition to any payments made under this subsection (a), the Illinois Department shall make the

adjustment payments required by Section 5-5.02 of this Code; provided, that in the case of any hospital reimbursed under a per case methodology, the Illinois Department shall add an amount equal to the product of the hospital's average length of stay, less one day, multiplied by 20, for inpatient hospital services rendered on or after September 1, 1991 and on or before September 30, 1992.

(b) (Blank)

(b-3) Potentially preventable readmissions.

(1) For fee for service discharges occurring on or after July 1, 2011, or on such later date as determined by rule, the Illinois Department may establish, by rule, a means of adjusting the rates of payment to hospitals that have an excess number of medical assistance readmissions as defined in accordance with the criteria set forth in paragraph (3) of this subsection, as determined by a risk adjusted comparison of the actual and expected number of readmissions in a hospital as described in paragraph (4) of this subsection, in accordance with paragraph (5) of this subsection. It is intended that the rate adjustment under this subsection, when combined with savings attributable to a reduction in readmissions, shall not result in an aggregate annual savings in excess of $40,000,000, relative to the base year. In developing any rules under this subsection, the Department shall consult with a statewide association that represents hospitals in all

areas of the State.

(2) Definitions. For purposes of this subsection:

(A) "Potentially preventable readmission" or "PPR" means a readmission to a hospital that follows a prior discharge from a hospital within a period to be defined by rule, but not to exceed 30 days, and that is clinically-related to the prior hospital admission.

(B) "Observed rate of readmission" means the number of admissions in each hospital that were actually followed by at least one PPR divided by the total number of admissions.

(C) "Expected rate of readmission" means a risk adjusted rate for each hospital that accounts for the severity of illness and age of patients at the time of discharge preceding the readmission.

(D) "Excess rate of readmission" means the difference between the observed rates of potentially preventable readmissions and the expected rate of potentially preventable readmissions for each hospital.

(E) "Behavioral health" means an admission that includes a primary diagnosis of a major mental health related condition, including, but not limited to, chemical dependency and substance abuse.

(3) Readmission criteria.

(A) A readmission is a return hospitalization

following a prior discharge that meets all of the following criteria:

(i) The readmission could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period.

(ii) The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge and including, but not limited to, the following:

(aa) The same or closely related condition or procedure as the prior discharge.

(bb) An infection or other complication of care.

(cc) A condition or procedure indicative of a failed surgical intervention.

(dd) An acute decompensation of a coexisting chronic disease.

(B) Readmissions, for the purposes of determining PPRs, excludes circumstances that include, but are not limited to, the following:

(i) The original discharge was a patient-initiated discharge and was Against Medical Advice (AMA) and the circumstances of such

discharge and readmission are documented in the patient's medical record.

(ii) The original discharge was for the purpose of securing treatment of a major or metastatic malignancy, multiple trauma, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), injuries resulting from violence, attempted suicide, transplants, multiple complex clinical conditions, burns, neonatal, or obstetrical admissions.

(iii) The readmission was a planned readmission.

(iv) The original discharge resulted in the patient being transferred to another acute care hospital.

(4) Methodology.

(A) Rate adjustments for each hospital shall be based on such hospital's Medicaid paid claims data for discharges that occurred between July 1, 2008 and June 30, 2009, hereinafter referred to as the base year. The Department shall complete an analysis of each hospital's potentially preventable readmissions in this base year and provide the results confidentially, including patient specific data, to each hospital free of charge at least 90 days prior to the effective date of any rate adjustments under this subsection.

(B) For each hospital, the Department shall calculate its observed rate of PPRs in the base year and its expected rate of PPRs for the rate year separately for behavioral health PPRs and all other PPRs. The expected rate of PPRs shall be calculated for the rate year, so that achieving the expected rate of PPRs would result in an aggregate savings of $40,000,000 annually, relative to the base year.

(C) Excess readmission rates are calculated based on the difference between the observed rate of PPRs in the rate year and the expected rate of PPRs for each hospital. This rate shall be calculated separately for behavioral health PPRs and all other PPRs. In the event the observed rate of PPRs for a hospital is lower than the expected rate of PPRs for that hospital, the excess number of readmissions shall be set at zero.

(D) In the event the observed rate of PPRs for hospitals in the aggregate in the rate year is lower than the expected rate of PPRs, the aggregate annual savings in excess of $40,000,000 shall be identified and such amount shall be used only for programs to improve care coordination or to preserve or enhance behavioral health services.

(5) Payment Calculation. If the aggregate annual savings attributable to a reduction in PPRs is less than $40,000,000, each hospital with excess readmissions as

identified in subparagraph (c) of paragraph (4) of this subsection shall have its payment rate adjusted by a readmission adjustment factor in order to achieve the $40,000,000 in aggregate savings. This adjustment may be made on a quarterly basis. In no event shall the application of the readmission adjustment factor to a hospital result in an annual savings attributable to a reduction in readmissions of more than 2% of the hospital's total annual payments under this Code for inpatient services.

(6) Reporting. On a quarterly basis, the Department shall issue a report free of charge to each hospital that includes, but is not limited to, its observed rate of PPRs, its expected rate of PPRs, and its readmission adjustment factor for prior quarters. The Department shall also provide such information on a quarterly basis for all hospitals free of charge to a statewide association that represents hospitals located in all areas of the State.

(b-5) Excepting county providers as defined in Article XV of this Code, hospitals licensed under the University of Illinois Hospital Act, and facilities operated by the Illinois Department of Mental Health and Developmental Disabilities (or its successor, the Department of Human Services), for outpatient services rendered on or after July 1, 1995 and before July 1, 1998 the Illinois Department shall reimburse children's hospitals, as defined in the Illinois

Administrative Code Section 149.50(c)(3), at the rates in effect on June 30, 1995, less that portion of such rates attributed by the Illinois Department to the outpatient indigent volume adjustment and shall reimburse all other hospitals at the rates in effect on June 30, 1995, less the portions of such rates attributed by the Illinois Department to the cost of medical education and attributed by the Illinois Department to the outpatient indigent volume adjustment. For outpatient services provided on or after July 1, 1998, reimbursement rates shall be established by rule.

(c) In addition to any other payments under this Code, the Illinois Department shall develop a hospital disproportionate share reimbursement methodology that, effective July 1, 1991, through September 30, 1992, shall reimburse hospitals sufficiently to expend the fee monies described in subsection (b) of Section 14-3 of this Code and the federal matching funds received by the Illinois Department as a result of expenditures made by the Illinois Department as required by this subsection (c) and Section 14-2 that are attributable to fee monies deposited in the Fund, less amounts applied to adjustment payments under Section 5-5.02.

(d) Critical Care Access Payments.

(1) In addition to any other payments made under this Code, the Illinois Department shall develop a reimbursement methodology that shall reimburse Critical Care Access Hospitals for the specialized services that

qualify them as Critical Care Access Hospitals. No adjustment payments shall be made under this subsection on or after July 1, 1995.

(2) "Critical Care Access Hospitals" includes, but is not limited to, hospitals that meet at least one of the following criteria:

(A) Hospitals located outside of a metropolitan statistical area that are designated as Level II Perinatal Centers and that provide a disproportionate share of perinatal services to recipients; or

(B) Hospitals that are designated as Level I Trauma Centers (adult or pediatric) and certain Level II Trauma Centers as determined by the Illinois Department; or

(C) Hospitals located outside of a metropolitan statistical area and that provide a disproportionate share of obstetrical services to recipients.

(e) Inpatient high volume adjustment. For hospital inpatient services, effective with rate periods beginning on or after October 1, 1993, in addition to rates paid for inpatient services by the Illinois Department, the Illinois Department shall make adjustment payments for inpatient services furnished by Medicaid high volume hospitals. The Illinois Department shall establish by rule criteria for qualifying as a Medicaid high volume hospital and shall establish by rule a reimbursement methodology for calculating these adjustment

payments to Medicaid high volume hospitals. No adjustment payment shall be made under this subsection for services rendered on or after July 1, 1995.

(f) The Illinois Department shall modify its current rules governing adjustment payments for targeted access, critical care access, and uncompensated care to classify those adjustment payments as not being payments to disproportionate share hospitals under Title XIX of the federal Social Security Act. Rules adopted under this subsection shall not be effective with respect to services rendered on or after July 1, 1995. The Illinois Department has no obligation to adopt or implement any rules or make any payments under this subsection for services rendered on or after July 1, 1995.

(f-5) The State recognizes that adjustment payments to hospitals providing certain services or incurring certain costs may be necessary to assure that recipients of medical assistance have adequate access to necessary medical services. These adjustments include payments for teaching costs and uncompensated care, trauma center payments, rehabilitation hospital payments, perinatal center payments, obstetrical care payments, targeted access payments, Medicaid high volume payments, and outpatient indigent volume payments. On or before April 1, 1995, the Illinois Department shall issue recommendations regarding (i) reimbursement mechanisms or adjustment payments to reflect these costs and services, including methods by which the payments may be calculated and

the method by which the payments may be financed, and (ii) reimbursement mechanisms or adjustment payments to reflect costs and services of federally qualified health centers with respect to recipients of medical assistance.

(g) If one or more hospitals file suit in any court challenging any part of this Article XIV, payments to hospitals under this Article XIV shall be made only to the extent that sufficient monies are available in the Fund and only to the extent that any monies in the Fund are not prohibited from disbursement under any order of the court.

(h) Payments under the disbursement methodology described in this Section are subject to approval by the federal government in an appropriate State plan amendment.

(i) The Illinois Department may by rule establish criteria for and develop methodologies for adjustment payments to hospitals participating under this Article.

(j) Hospital Residing Long Term Care Services. In addition to any other payments made under this Code, the Illinois Department may by rule establish criteria and develop methodologies for payments to hospitals for Hospital Residing Long Term Care Services.

(k) Critical Access Hospital outpatient payments. In addition to any other payments authorized under this Code, the Illinois Department shall reimburse critical access hospitals, as designated by the Illinois Department of Public Health in accordance with 42 CFR 485, Subpart F, for outpatient services

at an amount that is no less than the cost of providing such services, based on Medicare cost principles. Payments under this subsection shall be subject to appropriation.

(Source: P.A. 96-1382, eff. 1-1-11.)

Section 20. The Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act is amended by changing Section 4 as follows:

(320 ILCS 25/4) (from Ch. 67 1/2, par. 404)

Sec. 4. Amount of Grant.

(a) In general. Any individual 65 years or older or any individual who will become 65 years old during the calendar year in which a claim is filed, and any surviving spouse of such a claimant, who at the time of death received or was entitled to receive a grant pursuant to this Section, which surviving spouse will become 65 years of age within the 24 months immediately following the death of such claimant and which surviving spouse but for his or her age is otherwise qualified to receive a grant pursuant to this Section, and any disabled person whose annual household income is less than the income eligibility limitation, as defined in subsection (a-5) and whose household is liable for payment of property taxes accrued or has paid rent constituting property taxes accrued and is domiciled in this State at the time he or she files his or her claim is entitled to claim a grant under this Act. With

respect to claims filed by individuals who will become 65 years old during the calendar year in which a claim is filed, the amount of any grant to which that household is entitled shall be an amount equal to 1/12 of the amount to which the claimant would otherwise be entitled as provided in this Section, multiplied by the number of months in which the claimant was 65 in the calendar year in which the claim is filed.

(a-5) Income eligibility limitation. For purposes of this Section, "income eligibility limitation" means an amount for grant years 2008 and thereafter:

(1) less than $22,218 for a household containing one person;

(2) less than $29,480 for a household containing 2 persons; or

(3) less than $36,740 for a household containing 3 or more persons.

For 2009 claim year applications submitted during calendar year 2010, a household must have annual household income of less than $27,610 for a household containing one person; less than $36,635 for a household containing 2 persons; or less than $45,657 for a household containing 3 or more persons.

The Department on Aging may adopt rules such that on January 1, 2011, and thereafter, the foregoing household income eligibility limits may be changed to reflect the annual cost of living adjustment in Social Security and Supplemental Security Income benefits that are applicable to the year for which those

benefits are being reported as income on an application.

If a person files as a surviving spouse, then only his or her income shall be counted in determining his or her household income.

(b) Limitation. Except as otherwise provided in subsections (a) and (f) of this Section, the maximum amount of grant which a claimant is entitled to claim is the amount by which the property taxes accrued which were paid or payable during the last preceding tax year or rent constituting property taxes accrued upon the claimant's residence for the last preceding taxable year exceeds 3 1/2% of the claimant's household income for that year but in no event is the grant to exceed (i) $700 less 4.5% of household income for that year for those with a household income of $14,000 or less or (ii) $70 if household income for that year is more than $14,000.

(c) Public aid recipients. If household income in one or more months during a year includes cash assistance in excess of $55 per month from the Department of Healthcare and Family Services or the Department of Human Services (acting as successor to the Department of Public Aid under the Department of Human Services Act) which was determined under regulations of that Department on a measure of need that included an allowance for actual rent or property taxes paid by the recipient of that assistance, the amount of grant to which that household is entitled, except as otherwise provided in subsection (a), shall be the product of (1) the maximum amount

computed as specified in subsection (b) of this Section and (2) the ratio of the number of months in which household income did not include such cash assistance over $55 to the number twelve. If household income did not include such cash assistance over $55 for any months during the year, the amount of the grant to which the household is entitled shall be the maximum amount computed as specified in subsection (b) of this Section. For purposes of this paragraph (c), "cash assistance" does not include any amount received under the federal Supplemental Security Income (SSI) program.

(d) Joint ownership. If title to the residence is held jointly by the claimant with a person who is not a member of his or her household, the amount of property taxes accrued used in computing the amount of grant to which he or she is entitled shall be the same percentage of property taxes accrued as is the percentage of ownership held by the claimant in the residence.

(e) More than one residence. If a claimant has occupied more than one residence in the taxable year, he or she may claim only one residence for any part of a month. In the case of property taxes accrued, he or she shall prorate 1/12 of the total property taxes accrued on his or her residence to each month that he or she owned and occupied that residence; and, in the case of rent constituting property taxes accrued, shall prorate each month's rent payments to the residence actually occupied during that month.

(f) (Blank).

(g) Effective January 1, 2006, there is hereby established a program of pharmaceutical assistance to the aged and disabled, entitled the Illinois Seniors and Disabled Drug Coverage Program, which shall be administered by the Department of Healthcare and Family Services and the Department on Aging in accordance with this subsection, to consist of coverage of specified prescription drugs on behalf of beneficiaries of the program as set forth in this subsection.

To become a beneficiary under the program established under this subsection, a person must:

(1) be (i) 65 years of age or older or (ii) disabled; and

(2) be domiciled in this State; and

(3) enroll with a qualified Medicare Part D Prescription Drug Plan if eligible and apply for all available subsidies under Medicare Part D; and

(4) for the 2006 and 2007 claim years, have a maximum household income of (i) less than $21,218 for a household containing one person, (ii) less than $28,480 for a household containing 2 persons, or (iii) less than $35,740 for a household containing 3 or more persons; and

(5) for the 2008 claim year, have a maximum household income of (i) less than $22,218 for a household containing one person, (ii) $29,480 for a household containing 2 persons, or (iii) $36,740 for a household containing 3 or

more persons; and

(6) for 2009 claim year applications submitted during calendar year 2010, have annual household income of less than (i) $27,610 for a household containing one person; (ii) less than $36,635 for a household containing 2 persons; or (iii) less than $45,657 for a household containing 3 or more persons; and~~.~~

(7) as of September 1, 2011, have a maximum household income at or below 200% of the federal poverty level.

~~The Department of Healthcare and Family Services may adopt rules such that on January 1, 2011, and thereafter, the foregoing household income eligibility limits may be changed to reflect the annual cost of living adjustment in Social Security and Supplemental Security Income benefits that are applicable to the year for which those benefits are being reported as income on an application.~~

All individuals enrolled as of December 31, 2005, in the pharmaceutical assistance program operated pursuant to subsection (f) of this Section and all individuals enrolled as of December 31, 2005, in the SeniorCare Medicaid waiver program operated pursuant to Section 5-5.12a of the Illinois Public Aid Code shall be automatically enrolled in the program established by this subsection for the first year of operation without the need for further application, except that they must apply for Medicare Part D and the Low Income Subsidy under Medicare Part D. A person enrolled in the pharmaceutical assistance program

operated pursuant to subsection (f) of this Section as of December 31, 2005, shall not lose eligibility in future years due only to the fact that they have not reached the age of 65.

To the extent permitted by federal law, the Department may act as an authorized representative of a beneficiary in order to enroll the beneficiary in a Medicare Part D Prescription Drug Plan if the beneficiary has failed to choose a plan and, where possible, to enroll beneficiaries in the low-income subsidy program under Medicare Part D or assist them in enrolling in that program.

Beneficiaries under the program established under this subsection shall be divided into the following 4 eligibility groups:

(A) Eligibility Group 1 shall consist of beneficiaries who are not eligible for Medicare Part D coverage and who are:

(i) disabled and under age 65; or

(ii) age 65 or older, with incomes over 200% of the Federal Poverty Level; or

(iii) age 65 or older, with incomes at or below 200% of the Federal Poverty Level and not eligible for federally funded means-tested benefits due to immigration status.

(B) Eligibility Group 2 shall consist of beneficiaries who are eligible for Medicare Part D coverage.

(C) Eligibility Group 3 shall consist of beneficiaries

age 65 or older, with incomes at or below 200% of the Federal Poverty Level, who are not barred from receiving federally funded means-tested benefits due to immigration status and are not eligible for Medicare Part D coverage.

If the State applies and receives federal approval for a waiver under Title XIX of the Social Security Act, persons in Eligibility Group 3 shall continue to receive benefits through the approved waiver, and Eligibility Group 3 may be expanded to include disabled persons under age 65 with incomes under 200% of the Federal Poverty Level who are not eligible for Medicare and who are not barred from receiving federally funded means-tested benefits due to immigration status.

(D) Eligibility Group 4 shall consist of beneficiaries who are otherwise described in Eligibility Group 2 who have a diagnosis of HIV or AIDS.

Notwithstanding anything in this paragraph to the contrary, the Department of Healthcare and Family Services may establish by emergency rule changes in cost-sharing necessary to conform the cost of the program to the amounts appropriated for State fiscal year 2012 and future fiscal years. The program established under this subsection shall cover the cost of covered prescription drugs in excess of the beneficiary cost-sharing amounts set forth in this paragraph that are not covered by Medicare. In 2006, beneficiaries shall pay a co-payment of $2 for each prescription of a generic drug and $5

for each prescription of a brand-name drug. In future years, beneficiaries shall pay co-payments equal to the co-payments required under Medicare Part D for "other low-income subsidy eligible individuals" pursuant to 42 CFR 423.782(b). For individuals in Eligibility Groups 1, 2, and 3, once the program established under this subsection and Medicare combined have paid $1,750 in a year for covered prescription drugs, the beneficiary shall pay 20% of the cost of each prescription in addition to the co-payments set forth in this paragraph. For individuals in Eligibility Group 4, once the program established under this subsection and Medicare combined have paid $1,750 in a year for covered prescription drugs, the beneficiary shall pay 20% of the cost of each prescription in addition to the co-payments set forth in this paragraph unless the drug is included in the formulary of the Illinois AIDS Drug Assistance Program operated by the Illinois Department of Public Health and covered by the Medicare Part D Prescription Drug Plan in which the beneficiary is enrolled. If the drug is included in the formulary of the Illinois AIDS Drug Assistance Program and covered by the Medicare Part D Prescription Drug Plan in which the beneficiary is enrolled, individuals in Eligibility Group 4 shall continue to pay the co-payments set forth in this paragraph after the program established under this subsection and Medicare combined have paid $1,750 in a year for covered prescription drugs.

For beneficiaries eligible for Medicare Part D coverage,

the program established under this subsection shall pay 100% of the premiums charged by a qualified Medicare Part D Prescription Drug Plan for Medicare Part D basic prescription drug coverage, not including any late enrollment penalties. Qualified Medicare Part D Prescription Drug Plans may be limited by the Department of Healthcare and Family Services to those plans that sign a coordination agreement with the Department.

For ~~Notwithstanding Section 3.15, for~~ purposes of the program established under this subsection, the term "covered prescription drug" has the following meanings:

For Eligibility Group 1, "covered prescription drug" means: (1) any cardiovascular agent or drug; (2) any insulin or other prescription drug used in the treatment of diabetes, including syringe and needles used to administer the insulin; (3) any prescription drug used in the treatment of arthritis; (4) any prescription drug used in the treatment of cancer; (5) any prescription drug used in the treatment of Alzheimer's disease; (6) any prescription drug used in the treatment of Parkinson's disease; (7) any prescription drug used in the treatment of glaucoma; (8) any prescription drug used in the treatment of lung disease and smoking-related illnesses; (9) any prescription drug used in the treatment of osteoporosis; and (10) any prescription drug used in the treatment of multiple sclerosis. The Department may add additional therapeutic

classes by rule. The Department may adopt a preferred drug list within any of the classes of drugs described in items (1) through (10) of this paragraph. The specific drugs or therapeutic classes of covered prescription drugs shall be indicated by rule.

For Eligibility Group 2, "covered prescription drug" means those drugs covered by the Medicare Part D Prescription Drug Plan in which the beneficiary is enrolled.

For Eligibility Group 3, "covered prescription drug" means those drugs covered by the Medical Assistance Program under Article V of the Illinois Public Aid Code.

For Eligibility Group 4, "covered prescription drug" means those drugs covered by the Medicare Part D Prescription Drug Plan in which the beneficiary is enrolled.

~~An individual in Eligibility Group 1, 2, 3, or 4 may opt to receive a $25 monthly payment in lieu of the direct coverage described in this subsection.~~

Any person otherwise eligible for pharmaceutical assistance under this subsection whose covered drugs are covered by any public program is ineligible for assistance under this subsection to the extent that the cost of those drugs is covered by the other program.

The Department of Healthcare and Family Services shall establish by rule the methods by which it will provide for the

coverage called for in this subsection. Those methods may include direct reimbursement to pharmacies or the payment of a capitated amount to Medicare Part D Prescription Drug Plans.

For a pharmacy to be reimbursed under the program established under this subsection, it must comply with rules adopted by the Department of Healthcare and Family Services regarding coordination of benefits with Medicare Part D Prescription Drug Plans. A pharmacy may not charge a Medicare-enrolled beneficiary of the program established under this subsection more for a covered prescription drug than the appropriate Medicare cost-sharing less any payment from or on behalf of the Department of Healthcare and Family Services.

The Department of Healthcare and Family Services or the Department on Aging, as appropriate, may adopt rules regarding applications, counting of income, proof of Medicare status, mandatory generic policies, and pharmacy reimbursement rates and any other rules necessary for the cost-efficient operation of the program established under this subsection.

(h) A qualified individual is not entitled to duplicate benefits in a coverage period as a result of the changes made by this amendatory Act of the 96th General Assembly.

(Source: P.A. 95-208, eff. 8-16-07; 95-644, eff. 10-12-07; 95-876, eff. 8-21-08; 96-804, eff. 1-1-10; revised 9-16-10.)

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