



99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB4351

by Rep. Greg Harris

SYNOPSIS AS INTRODUCED:

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

Amends the Illinois Act on the Aging, the Disabled Persons Rehabilitation Act, and the Illinois Public Aid Code. Regarding services provided under the Community Care Program, the Home Services Program, the supportive living facilities program, and the nursing home prescreening project, provides that individuals with a score of 29 or higher based on the determination of need assessment tool are eligible to receive institutional and home and community-based long term care services until the State receives federal approval and implements an updated assessment tool. Requires the Department on Aging, the Department of Human Services, and the Department of Healthcare and Family Services to promulgate rules regarding the updated assessment tool, but prohibits those Departments from promulgating emergency rules regarding the updated assessment tool. Provides that the State shall not implement an updated assessment tool that causes more than 1% of then-current recipients to lose eligibility; and that anyone determined to be ineligible for services due to the updated assessment tool shall continue to be eligible for services for at least one year following that determination and must be reassessed no earlier than 11 months after that determination. Further amends the Illinois Public Aid Code by deleting a provision requiring the Department of Healthcare and Family Services to, subject to federal approval, on and after July 1, 2012, effectuate an increase in the determination of need scores from 29 to 37 for applicants for institutional and home and community-based long term care. Amends the Nursing Home Care Act. Provides that no individual receiving care in an institutional setting shall be involuntarily discharged as the result of the updated assessment tool until a transition plan has been developed by the Department on Aging or its designee and all care identified in the transition plan is available to the resident immediately upon discharge. Effective immediately.

LRB099 15530 KTG 39820 b

1 AN ACT concerning public aid.

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

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

6 (20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

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

18 (a) (blank);

19 (b) (blank);

20 (c) home care aide services;

21 (d) personal assistant services;

22 (e) adult day services;

23 (f) home-delivered meals;

- 1 (g) education in self-care;
2 (h) personal care services;
3 (i) adult day health services;
4 (j) habilitation services;
5 (k) respite care;
6 (k-5) community reintegration services;
7 (k-6) flexible senior services;
8 (k-7) medication management;
9 (k-8) emergency home response;
10 (l) other nonmedical social services that may enable
11 the person to become self-supporting; or
12 (m) clearinghouse for information provided by senior
13 citizen home owners who want to rent rooms to or share
14 living space with other senior citizens.

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

25 Beginning January 1, 2008, the Department shall require as
26 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 of
5 Public Aid (now Department of Healthcare and Family Services),
6 seek appropriate amendments under Sections 1915 and 1924 of the
7 Social Security Act. The purpose of the amendments shall be to
8 extend eligibility for home and community based services under
9 Sections 1915 and 1924 of the Social Security Act to persons
10 who transfer to or for the benefit of a spouse those amounts of
11 income and resources allowed under Section 1924 of the Social
12 Security Act. Subject to the approval of such amendments, the
13 Department shall extend the provisions of Section 5-4 of the
14 Illinois Public Aid Code to persons who, but for the provision
15 of home or community-based services, would require the level of
16 care provided in an institution, as is provided for in federal
17 law. Those persons no longer found to be eligible for receiving
18 noninstitutional services due to changes in the eligibility
19 criteria shall be given 45 days notice prior to actual
20 termination. Those persons receiving notice of termination may
21 contact the Department and request the determination be
22 appealed at any time during the 45 day notice period. The
23 target population identified for the purposes of this Section
24 are persons age 60 and older with an identified service need.
25 Priority shall be given to those who are at imminent risk of
26 institutionalization. The services shall be provided to

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

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

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

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

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

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

26 The Department shall increase the effectiveness of the

1 existing Community Care Program by:

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

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

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

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

1 additional covered services;

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

5 (A) bathing;

6 (B) grooming;

7 (C) toileting;

8 (D) nail care;

9 (E) transferring;

10 (F) respiratory services;

11 (G) exercise; or

12 (H) positioning;

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

19 (7) ensuring that the State may access maximum federal
20 matching funds by seeking approval for the Centers for
21 Medicare and Medicaid Services for modifications to the
22 State's home and community based services waiver and
23 additional waiver opportunities, including applying for
24 enrollment in the Balance Incentive Payment Program by May
25 1, 2013, in order to maximize federal matching funds; this
26 shall include, but not be limited to, modification that

1 reflects all changes in the Community Care Program services
2 and all increases in the services cost maximum;

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

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

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

1 order to address these improvements;

2 (11) requiring home care service providers to comply
3 with the rounding of hours worked provisions under the
4 federal Fair Labor Standards Act (FLSA) and as set forth in
5 29 CFR 785.48(b) by May 1, 2013;

6 (12) implementing any necessary policy changes or
7 promulgating any rules, no later than January 1, 2014, to
8 assist the Department of Healthcare and Family Services in
9 moving as many participants as possible, consistent with
10 federal regulations, into coordinated care plans if a care
11 coordination plan that covers long term care is available
12 in the recipient's area; and

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

15 Individuals with a score of 29 or higher based on the
16 determination of need (DON) assessment tool shall be eligible
17 to receive institutional and home and community-based long term
18 care services until such time that the State receives federal
19 approval and implements an updated assessment tool. The
20 Department must promulgate rules regarding the updated
21 assessment tool, but shall not promulgate emergency rules
22 regarding the updated assessment tool. The State shall not
23 implement an updated assessment tool that causes more than 1%
24 of then-current recipients to lose eligibility. Anyone
25 determined to be ineligible for services due to the updated
26 assessment tool shall continue to be eligible for services for

1 at least one year following that determination and must be
2 reassessed no earlier than 11 months after that determination.

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

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

19 Beginning on the effective date of this amendatory Act of
20 1991, no person may perform chore/housekeeping and home care
21 aide services under a program authorized by this Section unless
22 that person has been issued a certificate of pre-service to do
23 so by his or her employing agency. Information gathered to
24 effect such certification shall include (i) the person's name,
25 (ii) the date the person was hired by his or her current
26 employer, and (iii) the training, including dates and levels.

1 Persons engaged in the program authorized by this Section
2 before the effective date of this amendatory Act of 1991 shall
3 be issued a certificate of all pre- and in-service training
4 from his or her employer upon submitting the necessary
5 information. The employing agency shall be required to retain
6 records of all staff pre- and in-service training, and shall
7 provide such records to the Department upon request and upon
8 termination of the employer's contract with the Department. In
9 addition, the employing agency is responsible for the issuance
10 of certifications of in-service training completed to their
11 employees.

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

21 The Community Care Program Advisory Committee is created in
22 the Department on Aging. The Director shall appoint individuals
23 to serve in the Committee, who shall serve at their own
24 expense. Members of the Committee must abide by all applicable
25 ethics laws. The Committee shall advise the Department on
26 issues related to the Department's program of services to

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

23 Nominations may be presented from any agency or State
24 association with interest in the program. The Director, or his
25 or her designee, shall serve as the permanent co-chair of the
26 advisory committee. One other co-chair shall be nominated and

1 approved by the members of the committee on an annual basis.
2 Committee members' terms of appointment shall be for 4 years
3 with one-quarter of the appointees' terms expiring each year. A
4 member shall continue to serve until his or her replacement is
5 named. The Department shall fill vacancies that have a
6 remaining term of over one year, and this replacement shall
7 occur through the annual replacement of expiring terms. The
8 Director shall designate Department staff to provide technical
9 assistance and staff support to the committee. Department
10 representation shall not constitute membership of the
11 committee. All Committee papers, issues, recommendations,
12 reports, and meeting memoranda are advisory only. The Director,
13 or his or her designee, shall make a written report, as
14 requested by the Committee, regarding issues before the
15 Committee.

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

21 The requirement for reporting to the General Assembly shall
22 be satisfied by filing copies of the report with the Speaker,
23 the Minority Leader and the Clerk of the House of
24 Representatives and the President, the Minority Leader and the
25 Secretary of the Senate and the Legislative Research Unit, as
26 required by Section 3.1 of the General Assembly Organization

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

5 Those persons previously found eligible for receiving
6 non-institutional services whose services were discontinued
7 under the Emergency Budget Act of Fiscal Year 1992, and who do
8 not meet the eligibility standards in effect on or after July
9 1, 1992, shall remain ineligible on and after July 1, 1992.
10 Those persons previously not required to cost-share and who
11 were required to cost-share effective March 1, 1992, shall
12 continue to meet cost-share requirements on and after July 1,
13 1992. Beginning July 1, 1992, all clients will be required to
14 meet eligibility, cost-share, and other requirements and will
15 have services discontinued or altered when they fail to meet
16 these requirements.

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

22 The Department shall implement an electronic service
23 verification based on global positioning systems or other
24 cost-effective technology for the Community Care Program no
25 later than January 1, 2014.

26 The Department shall require, as a condition of

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

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

20 The Department shall implement co-payments for the
21 Community Care Program at the federally allowable maximum level
22 (i) beginning August 1, 2013, if the Auditor General has
23 reported that the Department has failed to comply with the
24 reporting requirements of Section 2-27 of the Illinois State
25 Auditing Act; or (ii) beginning June 1, 2014, if the Auditor
26 General has reported that the Department has not undertaken the

1 required actions listed in the report required by subsection
2 (a) of Section 2-27 of the Illinois State Auditing Act.

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

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

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

1 has complied with all Department policies.

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

7 (Source: P.A. 98-8, eff. 5-3-13; 98-1171, eff. 6-1-15; 99-143,
8 eff. 7-27-15.)

9 Section 10. The Disabled Persons Rehabilitation Act is
10 amended by changing Section 3 as follows:

11 (20 ILCS 2405/3) (from Ch. 23, par. 3434)

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

14 (a) To co-operate with the federal government in the
15 administration of the provisions of the federal Rehabilitation
16 Act of 1973, as amended, of the Workforce Investment Act of
17 1998, and of the federal Social Security Act to the extent and
18 in the manner provided in these Acts.

19 (b) To prescribe and supervise such courses of vocational
20 training and provide such other services as may be necessary
21 for the habilitation and rehabilitation of persons with one or
22 more disabilities, including the administrative activities
23 under subsection (e) of this Section, and to co-operate with
24 State and local school authorities and other recognized

1 agencies engaged in habilitation, rehabilitation and
2 comprehensive rehabilitation services; and to cooperate with
3 the Department of Children and Family Services regarding the
4 care and education of children with one or more disabilities.

5 (c) (Blank).

6 (d) To report in writing, to the Governor, annually on or
7 before the first day of December, and at such other times and
8 in such manner and upon such subjects as the Governor may
9 require. The annual report shall contain (1) a statement of the
10 existing condition of comprehensive rehabilitation services,
11 habilitation and rehabilitation in the State; (2) a statement
12 of suggestions and recommendations with reference to the
13 development of comprehensive rehabilitation services,
14 habilitation and rehabilitation in the State; and (3) an
15 itemized statement of the amounts of money received from
16 federal, State and other sources, and of the objects and
17 purposes to which the respective items of these several amounts
18 have been devoted.

19 (e) (Blank).

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

26 (1) personal assistant services;

- 1 (2) homemaker services;
- 2 (3) home-delivered meals;
- 3 (4) adult day care services;
- 4 (5) respite care;
- 5 (6) home modification or assistive equipment;
- 6 (7) home health services;
- 7 (8) electronic home response;
- 8 (9) brain injury behavioral/cognitive services;
- 9 (10) brain injury habilitation;
- 10 (11) brain injury pre-vocational services; or
- 11 (12) brain injury supported employment.

12 The Department shall establish eligibility standards for
13 such services taking into consideration the unique economic and
14 social needs of the population for whom they are to be
15 provided. Such eligibility standards may be based on the
16 recipient's ability to pay for services; provided, however,
17 that any portion of a person's income that is equal to or less
18 than the "protected income" level shall not be considered by
19 the Department in determining eligibility. The "protected
20 income" level shall be determined by the Department, shall
21 never be less than the federal poverty standard, and shall be
22 adjusted each year to reflect changes in the Consumer Price
23 Index For All Urban Consumers as determined by the United
24 States Department of Labor. The standards must provide that a
25 person may not have more than \$10,000 in assets to be eligible
26 for the services, and the Department may increase or decrease

1 the asset limitation by rule. The Department may not decrease
2 the asset level below \$10,000.

3 Individuals with a score of 29 or higher based on the
4 determination of need (DON) assessment tool shall be eligible
5 to receive institutional and home and community-based long term
6 care services until such time that the State receives federal
7 approval and implements an updated assessment tool. The
8 Department must promulgate rules regarding the updated
9 assessment tool, but shall not promulgate emergency rules
10 regarding the updated assessment tool. The State shall not
11 implement an updated assessment tool that causes more than 1%
12 of then-current recipients to lose eligibility. Anyone
13 determined to be ineligible for services due to the updated
14 assessment tool shall continue to be eligible for services for
15 at least one year following that determination and must be
16 reassessed no earlier than 11 months after that determination.

17 The services shall be provided, as established by the
18 Department by rule, to eligible persons to prevent unnecessary
19 or premature institutionalization, to the extent that the cost
20 of the services, together with the other personal maintenance
21 expenses of the persons, are reasonably related to the
22 standards established for care in a group facility appropriate
23 to their condition. These non-institutional services, pilot
24 projects or experimental facilities may be provided as part of
25 or in addition to those authorized by federal law or those
26 funded and administered by the Illinois Department on Aging.

1 The Department shall set rates and fees for services in a fair
2 and equitable manner. Services identical to those offered by
3 the Department on Aging shall be paid at the same rate.

4 Personal assistants shall be paid at a rate negotiated
5 between the State and an exclusive representative of personal
6 assistants under a collective bargaining agreement. In no case
7 shall the Department pay personal assistants an hourly wage
8 that is less than the federal minimum wage.

9 Solely for the purposes of coverage under the Illinois
10 Public Labor Relations Act (5 ILCS 315/), personal assistants
11 providing services under the Department's Home Services
12 Program shall be considered to be public employees and the
13 State of Illinois shall be considered to be their employer as
14 of the effective date of this amendatory Act of the 93rd
15 General Assembly, but not before. Solely for the purposes of
16 coverage under the Illinois Public Labor Relations Act, home
17 care and home health workers who function as personal
18 assistants and individual maintenance home health workers and
19 who also provide services under the Department's Home Services
20 Program shall be considered to be public employees, no matter
21 whether the State provides such services through direct
22 fee-for-service arrangements, with the assistance of a managed
23 care organization or other intermediary, or otherwise, and the
24 State of Illinois shall be considered to be the employer of
25 those persons as of January 29, 2013 (the effective date of
26 Public Act 97-1158), but not before except as otherwise

1 provided under this subsection (f). The State shall engage in
2 collective bargaining with an exclusive representative of home
3 care and home health workers who function as personal
4 assistants and individual maintenance home health workers
5 working under the Home Services Program concerning their terms
6 and conditions of employment that are within the State's
7 control. Nothing in this paragraph shall be understood to limit
8 the right of the persons receiving services defined in this
9 Section to hire and fire home care and home health workers who
10 function as personal assistants and individual maintenance
11 home health workers working under the Home Services Program or
12 to supervise them within the limitations set by the Home
13 Services Program. The State shall not be considered to be the
14 employer of home care and home health workers who function as
15 personal assistants and individual maintenance home health
16 workers working under the Home Services Program for any
17 purposes not specifically provided in Public Act 93-204 or
18 Public Act 97-1158, including but not limited to, purposes of
19 vicarious liability in tort and purposes of statutory
20 retirement or health insurance benefits. Home care and home
21 health workers who function as personal assistants and
22 individual maintenance home health workers and who also provide
23 services under the Department's Home Services Program shall not
24 be covered by the State Employees Group Insurance Act of 1971
25 (5 ILCS 375/).

26 The Department shall execute, relative to nursing home

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

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

21 To the extent permitted under the federal Social Security
22 Act, the Department, or the Department's authorized
23 representative, may recover the amount of moneys expended for
24 services provided to or in behalf of a person under this
25 Section by a claim against the person's estate or against the
26 estate of the person's surviving spouse, but no recovery may be

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

25 The Department shall submit an annual report on programs
26 and services provided under this Section. The report shall be

1 filed with the Governor and the General Assembly on or before
2 March 30 each year.

3 The requirement for reporting to the General Assembly shall
4 be satisfied by filing copies of the report with the Speaker,
5 the Minority Leader and the Clerk of the House of
6 Representatives and the President, the Minority Leader and the
7 Secretary of the Senate and the Legislative Research Unit, as
8 required by Section 3.1 of the General Assembly Organization
9 Act, and filing additional copies with the State Government
10 Report Distribution Center for the General Assembly as required
11 under paragraph (t) of Section 7 of the State Library Act.

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

15 (h) To cooperate and enter into any necessary agreements
16 with the Department of Employment Security for the provision of
17 job placement and job referral services to clients of the
18 Department, including job service registration of such clients
19 with Illinois Employment Security offices and making job
20 listings maintained by the Department of Employment Security
21 available to such clients.

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

26 (j) (Blank).

1 (k) (Blank).

2 (l) To establish, operate and maintain a Statewide Housing
3 Clearinghouse of information on available, government
4 subsidized housing accessible to persons with disabilities and
5 available privately owned housing accessible to persons with
6 disabilities. The information shall include but not be limited
7 to the location, rental requirements, access features and
8 proximity to public transportation of available housing. The
9 Clearinghouse shall consist of at least a computerized database
10 for the storage and retrieval of information and a separate or
11 shared toll free telephone number for use by those seeking
12 information from the Clearinghouse. Department offices and
13 personnel throughout the State shall also assist in the
14 operation of the Statewide Housing Clearinghouse. Cooperation
15 with local, State and federal housing managers shall be sought
16 and extended in order to frequently and promptly update the
17 Clearinghouse's information.

18 (m) To assure that the names and case records of persons
19 who received or are receiving services from the Department,
20 including persons receiving vocational rehabilitation, home
21 services, or other services, and those attending one of the
22 Department's schools or other supervised facility shall be
23 confidential and not be open to the general public. Those case
24 records and reports or the information contained in those
25 records and reports shall be disclosed by the Director only to
26 proper law enforcement officials, individuals authorized by a

1 court, the General Assembly or any committee or commission of
2 the General Assembly, and other persons and for reasons as the
3 Director designates by rule. Disclosure by the Director may be
4 only in accordance with other applicable law.

5 (Source: P.A. 98-1004, eff. 8-18-14; 99-143, eff. 7-27-15.)

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

8 (210 ILCS 45/3-402) (from Ch. 111 1/2, par. 4153-402)

9 Sec. 3-402. Involuntary transfer or discharge.

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

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

17 (b) When the transfer or discharge is mandated by the
18 physical safety of other residents, the facility staff, or
19 facility visitors, as documented in the clinical record.
20 The Department shall be notified prior to any such
21 involuntary transfer or discharge. The Department shall
22 immediately offer transfer, or discharge and relocation
23 assistance to residents transferred or discharged under
24 this subparagraph (b), and the Department may place

1 relocation teams as provided in Section 3-419 of this Act.

2 (c) When an identified offender is within the
3 provisional admission period defined in Section 1-120.3.
4 If the Identified Offender Report and Recommendation
5 prepared under Section 2-201.6 shows that the identified
6 offender poses a serious threat or danger to the physical
7 safety of other residents, the facility staff, or facility
8 visitors in the admitting facility and the facility
9 determines that it is unable to provide a safe environment
10 for the other residents, the facility staff, or facility
11 visitors, the facility shall transfer or discharge the
12 identified offender within 3 days after its receipt of the
13 Identified Offender Report and Recommendation.

14 No individual receiving care in an institutional setting
15 shall be involuntarily discharged as the result of the updated
16 determination of need (DON) assessment tool as provided in
17 Section 5-5 of the Illinois Public Aid Code until a transition
18 plan has been developed by the Department on Aging or its
19 designee and all care identified in the transition plan is
20 available to the resident immediately upon discharge.

21 (Source: P.A. 96-1372, eff. 7-29-10.)

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

24 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

1 (Text of Section before amendment by P.A. 99-407)

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

1 treatment of mental disorders or substance use disorders or
2 co-occurring mental health and substance use disorders is
3 determined using a uniform screening, assessment, and
4 evaluation process inclusive of criteria, for children and
5 adults; for purposes of this item (13), a uniform screening,
6 assessment, and evaluation process refers to a process that
7 includes an appropriate evaluation and, as warranted, a
8 referral; "uniform" does not mean the use of a singular
9 instrument, tool, or process that all must utilize; (14)
10 transportation and such other expenses as may be necessary;
11 (15) medical treatment of sexual assault survivors, as defined
12 in Section 1a of the Sexual Assault Survivors Emergency
13 Treatment Act, for injuries sustained as a result of the sexual
14 assault, including examinations and laboratory tests to
15 discover evidence which may be used in criminal proceedings
16 arising from the sexual assault; (16) the diagnosis and
17 treatment of sickle cell anemia; and (17) any other medical
18 care, and any other type of remedial care recognized under the
19 laws of this State, but not including abortions, or induced
20 miscarriages or premature births, unless, in the opinion of a
21 physician, such procedures are necessary for the preservation
22 of the life of the woman seeking such treatment, or except an
23 induced premature birth intended to produce a live viable child
24 and such procedure is necessary for the health of the mother or
25 her unborn child. The Illinois Department, by rule, shall
26 prohibit any physician from providing medical assistance to

1 anyone eligible therefor under this Code where such physician
2 has been found guilty of performing an abortion procedure in a
3 wilful and wanton manner upon a woman who was not pregnant at
4 the time such abortion procedure was performed. The term "any
5 other type of remedial care" shall include nursing care and
6 nursing home service for persons who rely on treatment by
7 spiritual means alone through prayer for healing.

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

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

22 Upon receipt of federal approval of an amendment to the
23 Illinois Title XIX State Plan for this purpose, the Department
24 shall authorize the Chicago Public Schools (CPS) to procure a
25 vendor or vendors to manufacture eyeglasses for individuals
26 enrolled in a school within the CPS system. CPS shall ensure

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

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

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

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

25 Notwithstanding any other provision of this Code and
26 subject to federal approval, the Department may adopt rules to

1 allow a dentist who is volunteering his or her service at no
2 cost to render dental services through an enrolled
3 not-for-profit health clinic without the dentist personally
4 enrolling as a participating provider in the medical assistance
5 program. A not-for-profit health clinic shall include a public
6 health clinic or Federally Qualified Health Center or other
7 enrolled provider, as determined by the Department, through
8 which dental services covered under this Section are performed.
9 The Department shall establish a process for payment of claims
10 for reimbursement for covered dental services rendered under
11 this provision.

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

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

22 The Illinois Department shall authorize the provision of,
23 and shall authorize payment for, screening by low-dose
24 mammography for the presence of occult breast cancer for women
25 35 years of age or older who are eligible for medical
26 assistance under this Article, as follows:

1 (A) A baseline mammogram for women 35 to 39 years of
2 age.

3 (B) An annual mammogram for women 40 years of age or
4 older.

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

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

15 (E) A screening MRI when medically necessary, as
16 determined by a physician licensed to practice medicine in
17 all of its branches.

18 All screenings shall include a physical breast exam,
19 instruction on self-examination and information regarding the
20 frequency of self-examination and its value as a preventative
21 tool. For purposes of this Section, "low-dose mammography"
22 means the x-ray examination of the breast using equipment
23 dedicated specifically for mammography, including the x-ray
24 tube, filter, compression device, and image receptor, with an
25 average radiation exposure delivery of less than one rad per
26 breast for 2 views of an average size breast. The term also

1 includes digital mammography.

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

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

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

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

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

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

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

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

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

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

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

19 Any medical or health care provider shall immediately
20 recommend, to any pregnant woman who is being provided prenatal
21 services and is suspected of drug abuse or is addicted as
22 defined in the Alcoholism and Other Drug Abuse and Dependency
23 Act, referral to a local substance abuse treatment provider
24 licensed by the Department of Human Services or to a licensed
25 hospital which provides substance abuse treatment services.
26 The Department of Healthcare and Family Services shall assure

1 coverage for the cost of treatment of the drug abuse or
2 addiction for pregnant recipients in accordance with the
3 Illinois Medicaid Program in conjunction with the Department of
4 Human Services.

5 All medical providers providing medical assistance to
6 pregnant women under this Code shall receive information from
7 the Department on the availability of services under the Drug
8 Free Families with a Future or any comparable program providing
9 case management services for addicted women, including
10 information on appropriate referrals for other social services
11 that may be needed by addicted women in addition to treatment
12 for addiction.

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

21 Neither the Department of Healthcare and Family Services
22 nor the Department of Human Services shall sanction the
23 recipient solely on the basis of her substance abuse.

24 The Illinois Department shall establish such regulations
25 governing the dispensing of health services under this Article
26 as it shall deem appropriate. The Department should seek the

1 advice of formal professional advisory committees appointed by
2 the Director of the Illinois Department for the purpose of
3 providing regular advice on policy and administrative matters,
4 information dissemination and educational activities for
5 medical and health care providers, and consistency in
6 procedures to the Illinois Department.

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

16 The sponsor must negotiate formal written contracts with
17 medical providers for physician services, inpatient and
18 outpatient hospital care, home health services, treatment for
19 alcoholism and substance abuse, and other services determined
20 necessary by the Illinois Department by rule for delivery by
21 Partnerships. Physician services must include prenatal and
22 obstetrical care. The Illinois Department shall reimburse
23 medical services delivered by Partnership providers to clients
24 in target areas according to provisions of this Article and the
25 Illinois Health Finance Reform Act, except that:

26 (1) Physicians participating in a Partnership and

1 providing certain services, which shall be determined by
2 the Illinois Department, to persons in areas covered by the
3 Partnership may receive an additional surcharge for such
4 services.

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

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

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

21 Nothing in this Section shall limit the free choice of
22 practitioners, hospitals, and other providers of medical
23 services by clients. In order to ensure patient freedom of
24 choice, the Illinois Department shall immediately promulgate
25 all rules and take all other necessary actions so that provided
26 services may be accessed from therapeutically certified

1 optometrists to the full extent of the Illinois Optometric
2 Practice Act of 1987 without discriminating between service
3 providers.

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

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

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

21 The rules and regulations of the Illinois Department shall
22 require that a written statement including the required opinion
23 of a physician shall accompany any claim for reimbursement for
24 abortions, or induced miscarriages or premature births. This
25 statement shall indicate what procedures were used in providing
26 such medical services.

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

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

22 The Illinois Department shall require all dispensers of
23 medical services, other than an individual practitioner or
24 group of practitioners, desiring to participate in the Medical
25 Assistance program established under this Article to disclose
26 all financial, beneficial, ownership, equity, surety or other

1 interests in any and all firms, corporations, partnerships,
2 associations, business enterprises, joint ventures, agencies,
3 institutions or other legal entities providing any form of
4 health care services in this State under this Article.

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

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

22 The Department has the discretion to limit the conditional
23 enrollment period for vendors based upon category of risk of
24 the vendor.

25 Prior to enrollment and during the conditional enrollment
26 period in the medical assistance program, all vendors shall be

1 subject to enhanced oversight, screening, and review based on
2 the risk of fraud, waste, and abuse that is posed by the
3 category of risk of the vendor. The Illinois Department shall
4 establish the procedures for oversight, screening, and review,
5 which may include, but need not be limited to: criminal and
6 financial background checks; fingerprinting; license,
7 certification, and authorization verifications; unscheduled or
8 unannounced site visits; database checks; prepayment audit
9 reviews; audits; payment caps; payment suspensions; and other
10 screening as required by federal or State law.

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

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

1 exceptions:

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

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

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

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

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

25 In the case of long term care facilities, within 5 days of
26 receipt by the facility of required prescreening information,

1 data for new admissions shall be entered into the Medical
2 Electronic Data Interchange (MEDI) or the Recipient
3 Eligibility Verification (REV) System or successor system, and
4 within 15 days of receipt by the facility of required
5 prescreening information, admission documents shall be
6 submitted through MEDI or REV or shall be submitted directly to
7 the Department of Human Services using required admission
8 forms. Effective September 1, 2014, admission documents,
9 including all prescreening information, must be submitted
10 through MEDI or REV. Confirmation numbers assigned to an
11 accepted transaction shall be retained by a facility to verify
12 timely submittal. Once an admission transaction has been
13 completed, all resubmitted claims following prior rejection
14 are subject to receipt no later than 180 days after the
15 admission transaction has been completed.

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

20 To the extent consistent with applicable information and
21 privacy, security, and disclosure laws, State and federal
22 agencies and departments shall provide the Illinois Department
23 access to confidential and other information and data necessary
24 to perform eligibility and payment verifications and other
25 Illinois Department functions. This includes, but is not
26 limited to: information pertaining to licensure;

1 certification; earnings; immigration status; citizenship; wage
2 reporting; unearned and earned income; pension income;
3 employment; supplemental security income; social security
4 numbers; National Provider Identifier (NPI) numbers; the
5 National Practitioner Data Bank (NPDB); program and agency
6 exclusions; taxpayer identification numbers; tax delinquency;
7 corporate information; and death records.

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

24 Beginning in fiscal year 2013, the Illinois Department
25 shall set forth a request for information to identify the
26 benefits of a pre-payment, post-adjudication, and post-edit

1 claims system with the goals of streamlining claims processing
2 and provider reimbursement, reducing the number of pending or
3 rejected claims, and helping to ensure a more transparent
4 adjudication process through the utilization of: (i) provider
5 data verification and provider screening technology; and (ii)
6 clinical code editing; and (iii) pre-pay, pre- or
7 post-adjudicated predictive modeling with an integrated case
8 management system with link analysis. Such a request for
9 information shall not be considered as a request for proposal
10 or as an obligation on the part of the Illinois Department to
11 take any action or acquire any products or services.

12 The Illinois Department shall establish policies,
13 procedures, standards and criteria by rule for the acquisition,
14 repair and replacement of orthotic and prosthetic devices and
15 durable medical equipment. Such rules shall provide, but not be
16 limited to, the following services: (1) immediate repair or
17 replacement of such devices by recipients; and (2) rental,
18 lease, purchase or lease-purchase of durable medical equipment
19 in a cost-effective manner, taking into consideration the
20 recipient's medical prognosis, the extent of the recipient's
21 needs, and the requirements and costs for maintaining such
22 equipment. Subject to prior approval, such rules shall enable a
23 recipient to temporarily acquire and use alternative or
24 substitute devices or equipment pending repairs or
25 replacements of any device or equipment previously authorized
26 for such recipient by the Department.

1 The Department shall execute, relative to the nursing home
2 prescreening project, written inter-agency agreements with the
3 Department of Human Services and the Department on Aging, to
4 effect the following: (i) intake procedures and common
5 eligibility criteria for those persons who are receiving
6 non-institutional services; and (ii) the establishment and
7 development of non-institutional services in areas of the State
8 where they are not currently available or are undeveloped; and
9 (iii) ~~(iii) notwithstanding any other provision of law, subject~~
10 ~~to federal approval, on and after July 1, 2012, an increase in~~
11 ~~the determination of need (DON) scores from 29 to 37 for~~
12 ~~applicants for institutional and home and community based long~~
13 ~~term care; if and only if federal approval is not granted, the~~
14 ~~Department may, in conjunction with other affected agencies,~~
15 ~~implement utilization controls or changes in benefit packages~~
16 ~~to effectuate a similar savings amount for this population; and~~
17 ~~(iv)~~ no later than July 1, 2013, minimum level of care
18 eligibility criteria for institutional and home and
19 community-based long term care; and (iv) ~~(v)~~ no later than
20 October 1, 2013, establish procedures to permit long term care
21 providers access to eligibility scores for individuals with an
22 admission date who are seeking or receiving services from the
23 long term care provider. In order to select the minimum level
24 of care eligibility criteria, the Governor shall establish a
25 workgroup that includes affected agency representatives and
26 stakeholders representing the institutional and home and

1 community-based long term care interests. This Section shall
2 not restrict the Department from implementing lower level of
3 care eligibility criteria for community-based services in
4 circumstances where federal approval has been granted.
5 Individuals with a score of 29 or higher based on the
6 determination of need (DON) assessment tool shall be eligible
7 to receive institutional and home and community-based long term
8 care services until such time that the State receives federal
9 approval and implements an updated assessment tool. The
10 Department must promulgate rules regarding the updated
11 assessment tool, but shall not promulgate emergency rules
12 regarding the updated assessment tool. The State shall not
13 implement an updated assessment tool that causes more than 1%
14 of then-current recipients to lose eligibility. Anyone
15 determined to be ineligible for services due to the updated
16 assessment tool shall continue to be eligible for services for
17 at least one year following that determination and must be
18 reassessed no earlier than 11 months after that determination.
19 No individual receiving care in an institutional setting shall
20 be involuntarily discharged as the result of the updated
21 assessment tool until a transition plan has been developed by
22 the Department on Aging or its designee and all care identified
23 in the transition plan is available to the resident immediately
24 upon discharge.

25 The Illinois Department shall develop and operate, in
26 cooperation with other State Departments and agencies and in

1 compliance with applicable federal laws and regulations,
2 appropriate and effective systems of health care evaluation and
3 programs for monitoring of utilization of health care services
4 and facilities, as it affects persons eligible for medical
5 assistance under this Code.

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

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

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

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

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

17 The period covered by each report shall be the 3 years
18 ending on the June 30 prior to the report. The report shall
19 include suggested legislation for consideration by the General
20 Assembly. The filing of one copy of the report with the
21 Speaker, one copy with the Minority Leader and one copy with
22 the Clerk of the House of Representatives, one copy with the
23 President, one copy with the Minority Leader and one copy with
24 the Secretary of the Senate, one copy with the Legislative
25 Research Unit, and such additional copies with the State
26 Government Report Distribution Center for the General Assembly

1 as is required under paragraph (t) of Section 7 of the State
2 Library Act shall be deemed sufficient to comply with this
3 Section.

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

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

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

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

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

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

1 Administration.

2 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
3 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
4 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
5 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
6 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-433, eff.
7 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

8 (Text of Section after amendment by P.A. 99-407)

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

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

1 laws of this State, but not including abortions, or induced
2 miscarriages or premature births, unless, in the opinion of a
3 physician, such procedures are necessary for the preservation
4 of the life of the woman seeking such treatment, or except an
5 induced premature birth intended to produce a live viable child
6 and such procedure is necessary for the health of the mother or
7 her unborn child. The Illinois Department, by rule, shall
8 prohibit any physician from providing medical assistance to
9 anyone eligible therefor under this Code where such physician
10 has been found guilty of performing an abortion procedure in a
11 wilful and wanton manner upon a woman who was not pregnant at
12 the time such abortion procedure was performed. The term "any
13 other type of remedial care" shall include nursing care and
14 nursing home service for persons who rely on treatment by
15 spiritual means alone through prayer for healing.

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

23 Notwithstanding any other provision of this Code, the
24 Illinois Department may not require, as a condition of payment
25 for any laboratory test authorized under this Article, that a
26 physician's handwritten signature appear on the laboratory

1 test order form. The Illinois Department may, however, impose
2 other appropriate requirements regarding laboratory test order
3 documentation.

4 Upon receipt of federal approval of an amendment to the
5 Illinois Title XIX State Plan for this purpose, the Department
6 shall authorize the Chicago Public Schools (CPS) to procure a
7 vendor or vendors to manufacture eyeglasses for individuals
8 enrolled in a school within the CPS system. CPS shall ensure
9 that its vendor or vendors are enrolled as providers in the
10 medical assistance program and in any capitated Medicaid
11 managed care entity (MCE) serving individuals enrolled in a
12 school within the CPS system. Under any contract procured under
13 this provision, the vendor or vendors must serve only
14 individuals enrolled in a school within the CPS system. Claims
15 for services provided by CPS's vendor or vendors to recipients
16 of benefits in the medical assistance program under this Code,
17 the Children's Health Insurance Program, or the Covering ALL
18 KIDS Health Insurance Program shall be submitted to the
19 Department or the MCE in which the individual is enrolled for
20 payment and shall be reimbursed at the Department's or the
21 MCE's established rates or rate methodologies for eyeglasses.

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

1 the Department of Public Aid:

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

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

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

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

1 short bowel syndrome when the prescribing physician has issued
2 a written order stating that the amino acid-based elemental
3 formula is medically necessary.

4 The Illinois Department shall authorize the provision of,
5 and shall authorize payment for, screening by low-dose
6 mammography for the presence of occult breast cancer for women
7 35 years of age or older who are eligible for medical
8 assistance under this Article, as follows:

9 (A) A baseline mammogram for women 35 to 39 years of
10 age.

11 (B) An annual mammogram for women 40 years of age or
12 older.

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

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

23 (E) A screening MRI when medically necessary, as
24 determined by a physician licensed to practice medicine in
25 all of its branches.

26 All screenings shall include a physical breast exam,

1 instruction on self-examination and information regarding the
2 frequency of self-examination and its value as a preventative
3 tool. For purposes of this Section, "low-dose mammography"
4 means the x-ray examination of the breast using equipment
5 dedicated specifically for mammography, including the x-ray
6 tube, filter, compression device, and image receptor, with an
7 average radiation exposure delivery of less than one rad per
8 breast for 2 views of an average size breast. The term also
9 includes digital mammography and includes breast
10 tomosynthesis. As used in this Section, the term "breast
11 tomosynthesis" means a radiologic procedure that involves the
12 acquisition of projection images over the stationary breast to
13 produce cross-sectional digital three-dimensional images of
14 the breast.

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

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

24 The Department shall convene an expert panel including
25 representatives of hospitals, free-standing mammography
26 facilities, and doctors, including radiologists, to establish

1 quality standards for mammography.

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

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

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

21 The Department shall establish a methodology to remind
22 women who are age-appropriate for screening mammography, but
23 who have not received a mammogram within the previous 18
24 months, of the importance and benefit of screening mammography.
25 The Department shall work with experts in breast cancer
26 outreach and patient navigation to optimize these reminders and

1 shall establish a methodology for evaluating their
2 effectiveness and modifying the methodology based on the
3 evaluation.

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

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

24 The Department shall require all networks of care to
25 develop a means either internally or by contract with experts
26 in navigation and community outreach to navigate cancer

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

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

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

26 The Illinois Department, in cooperation with the

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

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

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

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

1 Nothing in this Section shall be construed to require that the
2 sponsor organization be a medical organization.

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

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

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

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

25 Medical providers shall be required to meet certain
26 qualifications to participate in Partnerships to ensure the

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

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

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

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

1 then the records must be retained until the audit is completed
2 and every exception is resolved. The Illinois Department shall
3 require health care providers to make available, when
4 authorized by the patient, in writing, the medical records in a
5 timely fashion to other health care providers who are treating
6 or serving persons eligible for Medical Assistance under this
7 Article. All dispensers of medical services shall be required
8 to maintain and retain business and professional records
9 sufficient to fully and accurately document the nature, scope,
10 details and receipt of the health care provided to persons
11 eligible for medical assistance under this Code, in accordance
12 with regulations promulgated by the Illinois Department. The
13 rules and regulations shall require that proof of the receipt
14 of prescription drugs, dentures, prosthetic devices and
15 eyeglasses by eligible persons under this Section accompany
16 each claim for reimbursement submitted by the dispenser of such
17 medical services. No such claims for reimbursement shall be
18 approved for payment by the Illinois Department without such
19 proof of receipt, unless the Illinois Department shall have put
20 into effect and shall be operating a system of post-payment
21 audit and review which shall, on a sampling basis, be deemed
22 adequate by the Illinois Department to assure that such drugs,
23 dentures, prosthetic devices and eyeglasses for which payment
24 is being made are actually being received by eligible
25 recipients. Within 90 days after September 16, 1984 (the
26 effective date of Public Act 83-1439) ~~this amendatory Act of~~

1 ~~1984~~, the Illinois Department shall establish a current list of
2 acquisition costs for all prosthetic devices and any other
3 items recognized as medical equipment and supplies
4 reimbursable under this Article and shall update such list on a
5 quarterly basis, except that the acquisition costs of all
6 prescription drugs shall be updated no less frequently than
7 every 30 days as required by Section 5-5.12.

8 The rules and regulations of the Illinois Department shall
9 require that a written statement including the required opinion
10 of a physician shall accompany any claim for reimbursement for
11 abortions, or induced miscarriages or premature births. This
12 statement shall indicate what procedures were used in providing
13 such medical services.

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

25 Notwithstanding any other law to the contrary, the Illinois
26 Department shall, within 365 days after August 15, 2014 (the

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

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

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

26 Enrollment of a vendor shall be subject to a provisional

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

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

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

24 The Department shall define or specify the following: (i)
25 by provider notice, the "category of risk of the vendor" for
26 each type of vendor, which shall take into account the level of

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

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

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

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

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

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

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

12 In the case of long term care facilities, within 5 days of
13 receipt by the facility of required prescreening information,
14 data for new admissions shall be entered into the Medical
15 Electronic Data Interchange (MEDI) or the Recipient
16 Eligibility Verification (REV) System or successor system, and
17 within 15 days of receipt by the facility of required
18 prescreening information, admission documents shall be
19 submitted through MEDI or REV or shall be submitted directly to
20 the Department of Human Services using required admission
21 forms. Effective September 1, 2014, admission documents,
22 including all prescreening information, must be submitted
23 through MEDI or REV. Confirmation numbers assigned to an
24 accepted transaction shall be retained by a facility to verify
25 timely submittal. Once an admission transaction has been
26 completed, all resubmitted claims following prior rejection

1 are subject to receipt no later than 180 days after the
2 admission transaction has been completed.

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

7 To the extent consistent with applicable information and
8 privacy, security, and disclosure laws, State and federal
9 agencies and departments shall provide the Illinois Department
10 access to confidential and other information and data necessary
11 to perform eligibility and payment verifications and other
12 Illinois Department functions. This includes, but is not
13 limited to: information pertaining to licensure;
14 certification; earnings; immigration status; citizenship; wage
15 reporting; unearned and earned income; pension income;
16 employment; supplemental security income; social security
17 numbers; National Provider Identifier (NPI) numbers; the
18 National Practitioner Data Bank (NPDB); program and agency
19 exclusions; taxpayer identification numbers; tax delinquency;
20 corporate information; and death records.

21 The Illinois Department shall enter into agreements with
22 State agencies and departments, and is authorized to enter into
23 agreements with federal agencies and departments, under which
24 such agencies and departments shall share data necessary for
25 medical assistance program integrity functions and oversight.
26 The Illinois Department shall develop, in cooperation with

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

1 repair and replacement of orthotic and prosthetic devices and
2 durable medical equipment. Such rules shall provide, but not be
3 limited to, the following services: (1) immediate repair or
4 replacement of such devices by recipients; and (2) rental,
5 lease, purchase or lease-purchase of durable medical equipment
6 in a cost-effective manner, taking into consideration the
7 recipient's medical prognosis, the extent of the recipient's
8 needs, and the requirements and costs for maintaining such
9 equipment. Subject to prior approval, such rules shall enable a
10 recipient to temporarily acquire and use alternative or
11 substitute devices or equipment pending repairs or
12 replacements of any device or equipment previously authorized
13 for such recipient by the Department.

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

1 ~~Department may, in conjunction with other affected agencies,~~
2 ~~implement utilization controls or changes in benefit packages~~
3 ~~to effectuate a similar savings amount for this population; and~~
4 ~~(iv)~~ no later than July 1, 2013, minimum level of care
5 eligibility criteria for institutional and home and
6 community-based long term care; and (iv) ~~(v)~~ no later than
7 October 1, 2013, establish procedures to permit long term care
8 providers access to eligibility scores for individuals with an
9 admission date who are seeking or receiving services from the
10 long term care provider. In order to select the minimum level
11 of care eligibility criteria, the Governor shall establish a
12 workgroup that includes affected agency representatives and
13 stakeholders representing the institutional and home and
14 community-based long term care interests. This Section shall
15 not restrict the Department from implementing lower level of
16 care eligibility criteria for community-based services in
17 circumstances where federal approval has been granted.
18 Individuals with a score of 29 or higher based on the
19 determination of need (DON) assessment tool shall be eligible
20 to receive institutional and home and community-based long term
21 care services until such time that the State receives federal
22 approval and implements an updated assessment tool. The
23 Department must promulgate rules regarding the updated
24 assessment tool, but shall not promulgate emergency rules
25 regarding the updated assessment tool. The State shall not
26 implement an updated assessment tool that causes more than 1%

1 of then-current recipients to lose eligibility. Anyone
2 determined to be ineligible for services due to the updated
3 assessment tool shall continue to be eligible for services for
4 at least one year following that determination and must be
5 reassessed no earlier than 11 months after that determination.
6 No individual receiving care in an institutional setting shall
7 be involuntarily discharged as the result of the updated
8 assessment tool until a transition plan has been developed by
9 the Department on Aging or its designee and all care identified
10 in the transition plan is available to the resident immediately
11 upon discharge.

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

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

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

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

26 (c) current rate structures and proposed changes in

1 those rate structures for the various medical vendors; and
2 (d) efforts at utilization review and control by the
3 Illinois Department.

4 The period covered by each report shall be the 3 years
5 ending on the June 30 prior to the report. The report shall
6 include suggested legislation for consideration by the General
7 Assembly. The filing of one copy of the report with the
8 Speaker, one copy with the Minority Leader and one copy with
9 the Clerk of the House of Representatives, one copy with the
10 President, one copy with the Minority Leader and one copy with
11 the Secretary of the Senate, one copy with the Legislative
12 Research Unit, and such additional copies with the State
13 Government Report Distribution Center for the General Assembly
14 as is required under paragraph (t) of Section 7 of the State
15 Library Act shall be deemed sufficient to comply with this
16 Section.

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

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

1 Section 5-5e.

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

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

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

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

15 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
16 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
17 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
18 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
19 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section
20 99 of P.A. 99-407 for its effective date); 99-433, eff.
21 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

22 (305 ILCS 5/5-5.01a)

23 Sec. 5-5.01a. Supportive living facilities program. The
24 Department shall establish and provide oversight for a program
25 of supportive living facilities that seek to promote resident

1 independence, dignity, respect, and well-being in the most
2 cost-effective manner.

3 A supportive living facility is either a free-standing
4 facility or a distinct physical and operational entity within a
5 nursing facility. A supportive living facility integrates
6 housing with health, personal care, and supportive services and
7 is a designated setting that offers residents their own
8 separate, private, and distinct living units.

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

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

26 The Department may adopt rules to implement this Section.

1 Rules that establish or modify the services, standards, and
2 conditions for participation in the program shall be adopted by
3 the Department in consultation with the Department on Aging,
4 the Department of Rehabilitation Services, and the Department
5 of Mental Health and Developmental Disabilities (or their
6 successor agencies).

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

12 Individuals with a score of 29 or higher based on the
13 determination of need (DON) assessment tool shall be eligible
14 to receive institutional and home and community-based long term
15 care services until such time that the State receives federal
16 approval and implements an updated assessment tool. The
17 Department must promulgate rules regarding the updated
18 assessment tool, but shall not promulgate emergency rules
19 regarding the updated assessment tool. The State shall not
20 implement an updated assessment tool that causes more than 1%
21 of then-current recipients to lose eligibility. Anyone
22 determined to be ineligible for services due to the updated
23 assessment tool shall continue to be eligible for services for
24 at least one year following that determination and must be
25 reassessed no earlier than 11 months after that determination.

26 (Source: P.A. 98-651, eff. 6-16-14.)

1 Section 95. No acceleration or delay. Where this Act makes
2 changes in a statute that is represented in this Act by text
3 that is not yet or no longer in effect (for example, a Section
4 represented by multiple versions), the use of that text does
5 not accelerate or delay the taking effect of (i) the changes
6 made by this Act or (ii) provisions derived from any other
7 Public Act.

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