



Rep. Gregory Harris

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1 AMENDMENT TO HOUSE BILL 4351

2 AMENDMENT NO. _____. Amend House Bill 4351 by replacing
3 everything after the enacting clause with the following:

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

1 limited to, any or all of the following:

2 (a) (blank);

3 (b) (blank);

4 (c) home care aide services;

5 (d) personal assistant services;

6 (e) adult day services;

7 (f) home-delivered meals;

8 (g) education in self-care;

9 (h) personal care services;

10 (i) adult day health services;

11 (j) habilitation services;

12 (k) respite care;

13 (k-5) community reintegration services;

14 (k-6) flexible senior services;

15 (k-7) medication management;

16 (k-8) emergency home response;

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

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

22 Individuals who meet the following criteria shall have
23 equal access to services under the Community Care Program: ~~The~~
24 ~~Department shall establish eligibility standards for such~~
25 ~~services.~~

26 (a) are 60 years old or older;

1 (b) are U.S. citizens or legal aliens;

2 (c) are residents of Illinois;

3 (d) have non-exempt assets of \$17,500 or less;

4 non-exempt assets do not include home, car, or personal
5 furnishings; and

6 (e) have an assessed need for long term care, as
7 provided in this Section, and are at risk for nursing
8 facility placement as measured by the determination of need
9 assessment tool or a future updated assessment tool.

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

18 Need for long term care shall be determined as follows:

19 Individuals with a score of 29 or higher based on the
20 determination of need (DON) assessment tool shall be eligible
21 to receive institutional and home and community-based long term
22 care services until such time that the State receives federal
23 approval and implements an updated assessment tool, and those
24 individuals are found to be ineligible under that updated
25 assessment tool. Anyone determined to be ineligible for
26 services due to the updated assessment tool shall continue to

1 be eligible for services for at least one year following that
2 determination and must be reassessed no earlier than 11 months
3 after that determination. The Department must adopt rules
4 through the regular rulemaking process regarding the updated
5 assessment tool, and shall not adopt emergency or peremptory
6 rules regarding the updated assessment tool. The State shall
7 not implement an updated assessment tool that causes more than
8 1% of then-current recipients to lose eligibility.

9 Service cost maximums shall be set at levels no lower than
10 the service cost maximums that were in effect as of January 1,
11 2016. Service cost maximums shall be increased accordingly to
12 reflect any rate increases.

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

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

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

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

21 As part of the Department on Aging's routine training of
22 case managers and case manager supervisors, the Department may
23 include information on family futures planning for persons who
24 are age 60 or older and who are caregivers of their adult
25 children with developmental disabilities. The content of the
26 training shall be at the Department's discretion.

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

11 The Department, or the Department's authorized
12 representative, may recover the amount of moneys expended for
13 services provided to or in behalf of a person under this
14 Section by a claim against the person's estate or against the
15 estate of the person's surviving spouse, but no recovery may be
16 had until after the death of the surviving spouse, if any, and
17 then only at such time when there is no surviving child who is
18 under age 21 or blind or who has a permanent and total
19 disability. This paragraph, however, shall not bar recovery, at
20 the death of the person, of moneys for services provided to the
21 person or in behalf of the person under this Section to which
22 the person was not entitled; provided that such recovery shall
23 not be enforced against any real estate while it is occupied as
24 a homestead by the surviving spouse or other dependent, if no
25 claims by other creditors have been filed against the estate,
26 or, if such claims have been filed, they remain dormant for

1 failure of prosecution or failure of the claimant to compel
2 administration of the estate for the purpose of payment. This
3 paragraph shall not bar recovery from the estate of a spouse,
4 under Sections 1915 and 1924 of the Social Security Act and
5 Section 5-4 of the Illinois Public Aid Code, who precedes a
6 person receiving services under this Section in death. All
7 moneys for services paid to or in behalf of the person under
8 this Section shall be claimed for recovery from the deceased
9 spouse's estate. "Homestead", as used in this paragraph, means
10 the dwelling house and contiguous real estate occupied by a
11 surviving spouse or relative, as defined by the rules and
12 regulations of the Department of Healthcare and Family
13 Services, regardless of the value of the property.

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

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

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

26 (3) ensuring that the participants have the right to

1 choose the services contained in their care plan and to
2 direct how those services are provided, based on
3 administrative rules established by the Department;

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

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

19 (A) bathing;

20 (B) grooming;

21 (C) toileting;

22 (D) nail care;

23 (E) transferring;

24 (F) respiratory services;

25 (G) exercise; or

26 (H) positioning;

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

7 (7) ensuring that the State may access maximum federal
8 matching funds by seeking approval for the Centers for
9 Medicare and Medicaid Services for modifications to the
10 State's home and community based services waiver and
11 additional waiver opportunities, including applying for
12 enrollment in the Balance Incentive Payment Program by May
13 1, 2013, in order to maximize federal matching funds; this
14 shall include, but not be limited to, modification that
15 reflects all changes in the Community Care Program services
16 and all increases in the services cost maximum;

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

20 (9) ensuring that services are authorized accurately
21 and consistently for the Community Care Program (CCP); the
22 Department shall implement a Service Authorization policy
23 directive; the purpose shall be to ensure that eligibility
24 and services are authorized accurately and consistently in
25 the CCP program; the policy directive shall clarify service
26 authorization guidelines to Care Coordination Units and

1 Community Care Program providers no later than May 1, 2013;

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

16 (11) requiring home care service providers to comply
17 with the rounding of hours worked provisions under the
18 federal Fair Labor Standards Act (FLSA) and as set forth in
19 29 CFR 785.48(b) by May 1, 2013;

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

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

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 Rehabilitation of Persons with
10 Disabilities Act is 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, and those
8 individuals are found to be ineligible under that updated
9 assessment tool. Anyone determined to be ineligible for
10 services due to the updated assessment tool shall continue to
11 be eligible for services for at least one year following that
12 determination and must be reassessed no earlier than 11 months
13 after that determination. The Department must adopt rules
14 through the regular rulemaking process regarding the updated
15 assessment tool, and shall not adopt emergency or peremptory
16 rules regarding the updated assessment tool. The State shall
17 not implement an updated assessment tool that causes more than
18 1% of then-current recipients to lose eligibility.

19 Service cost maximums shall be set at levels no lower than
20 the service cost maximums that were in effect as of January 1,
21 2016. Service cost maximums shall be increased accordingly to
22 reflect any rate increases.

23 The services shall be provided, as established by the
24 Department by rule, to eligible persons to prevent unnecessary
25 or premature institutionalization, to the extent that the cost
26 of the services, together with the other personal maintenance

1 expenses of the persons, are reasonably related to the
2 standards established for care in a group facility appropriate
3 to their condition. These non-institutional services, pilot
4 projects or experimental facilities may be provided as part of
5 or in addition to those authorized by federal law or those
6 funded and administered by the Illinois Department on Aging.
7 The Department shall set rates and fees for services in a fair
8 and equitable manner. Services identical to those offered by
9 the Department on Aging shall be paid at the same rate.

10 Personal assistants shall be paid at a rate negotiated
11 between the State and an exclusive representative of personal
12 assistants under a collective bargaining agreement. In no case
13 shall the Department pay personal assistants an hourly wage
14 that is less than the federal minimum wage.

15 Solely for the purposes of coverage under the Illinois
16 Public Labor Relations Act (5 ILCS 315/), personal assistants
17 providing services under the Department's Home Services
18 Program shall be considered to be public employees and the
19 State of Illinois shall be considered to be their employer as
20 of the effective date of this amendatory Act of the 93rd
21 General Assembly, but not before. Solely for the purposes of
22 coverage under the Illinois Public Labor Relations Act, home
23 care and home health workers who function as personal
24 assistants and individual maintenance home health workers and
25 who also provide services under the Department's Home Services
26 Program shall be considered to be public employees, no matter

1 whether the State provides such services through direct
2 fee-for-service arrangements, with the assistance of a managed
3 care organization or other intermediary, or otherwise, and the
4 State of Illinois shall be considered to be the employer of
5 those persons as of January 29, 2013 (the effective date of
6 Public Act 97-1158), but not before except as otherwise
7 provided under this subsection (f). The State shall engage in
8 collective bargaining with an exclusive representative of home
9 care and home health workers who function as personal
10 assistants and individual maintenance home health workers
11 working under the Home Services Program concerning their terms
12 and conditions of employment that are within the State's
13 control. Nothing in this paragraph shall be understood to limit
14 the right of the persons receiving services defined in this
15 Section to hire and fire home care and home health workers who
16 function as personal assistants and individual maintenance
17 home health workers working under the Home Services Program or
18 to supervise them within the limitations set by the Home
19 Services Program. The State shall not be considered to be the
20 employer of home care and home health workers who function as
21 personal assistants and individual maintenance home health
22 workers working under the Home Services Program for any
23 purposes not specifically provided in Public Act 93-204 or
24 Public Act 97-1158, including but not limited to, purposes of
25 vicarious liability in tort and purposes of statutory
26 retirement or health insurance benefits. Home care and home

1 health workers who function as personal assistants and
2 individual maintenance home health workers and who also provide
3 services under the Department's Home Services Program shall not
4 be covered by the State Employees Group Insurance Act of 1971
5 (5 ILCS 375/).

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

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

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

1 the dwelling house and contiguous real estate occupied by a
2 surviving spouse or relative, as defined by the rules and
3 regulations of the Department of Healthcare and Family
4 Services, regardless of the value of the property.

5 The Department shall submit an annual report on programs
6 and services provided under this Section. The report shall be
7 filed with the Governor and the General Assembly on or before
8 March 30 each year.

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

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

21 (h) To cooperate and enter into any necessary agreements
22 with the Department of Employment Security for the provision of
23 job placement and job referral services to clients of the
24 Department, including job service registration of such clients
25 with Illinois Employment Security offices and making job
26 listings maintained by the Department of Employment Security

1 available to such clients.

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

6 (j) (Blank).

7 (k) (Blank).

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

24 (m) To assure that the names and case records of persons
25 who received or are receiving services from the Department,
26 including persons receiving vocational rehabilitation, home

1 services, or other services, and those attending one of the
2 Department's schools or other supervised facility shall be
3 confidential and not be open to the general public. Those case
4 records and reports or the information contained in those
5 records and reports shall be disclosed by the Director only to
6 proper law enforcement officials, individuals authorized by a
7 court, the General Assembly or any committee or commission of
8 the General Assembly, and other persons and for reasons as the
9 Director designates by rule. Disclosure by the Director may be
10 only in accordance with other applicable law.

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

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

14 (210 ILCS 45/3-402) (from Ch. 111 1/2, par. 4153-402)

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

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

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

23 (b) When the transfer or discharge is mandated by the
24 physical safety of other residents, the facility staff, or

1 facility visitors, as documented in the clinical record.
2 The Department shall be notified prior to any such
3 involuntary transfer or discharge. The Department shall
4 immediately offer transfer, or discharge and relocation
5 assistance to residents transferred or discharged under
6 this subparagraph (b), and the Department may place
7 relocation teams as provided in Section 3-419 of this Act.

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

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

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

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

4 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

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

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

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

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

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

1 documentation.

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

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

26 (1) dental services provided by or under the

1 supervision of a dentist; and

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

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

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

21 The Department of Healthcare and Family Services must
22 provide coverage and reimbursement for amino acid-based
23 elemental formulas, regardless of delivery method, for the
24 diagnosis and treatment of (i) eosinophilic disorders and (ii)
25 short bowel syndrome when the prescribing physician has issued
26 a written order stating that the amino acid-based elemental

1 formula is medically necessary.

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

7 (A) A baseline mammogram for women 35 to 39 years of
8 age.

9 (B) An annual mammogram for women 40 years of age or
10 older.

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

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

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

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

1 tool. For purposes of this Section, "low-dose mammography"
2 means the x-ray examination of the breast using equipment
3 dedicated specifically for mammography, including the x-ray
4 tube, filter, compression device, and image receptor, with an
5 average radiation exposure delivery of less than one rad per
6 breast for 2 views of an average size breast. The term also
7 includes digital mammography.

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

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

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

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

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

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

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

23 The Department shall establish a performance goal for
24 primary care providers with respect to their female patients
25 over age 40 receiving an annual mammogram. This performance
26 goal shall be used to provide additional reimbursement in the

1 form of a quality performance bonus to primary care providers
2 who meet that goal.

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

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

25 Any medical or health care provider shall immediately
26 recommend, to any pregnant woman who is being provided prenatal

1 services and is suspected of drug abuse or is addicted as
2 defined in the Alcoholism and Other Drug Abuse and Dependency
3 Act, referral to a local substance abuse treatment provider
4 licensed by the Department of Human Services or to a licensed
5 hospital which provides substance abuse treatment services.
6 The Department of Healthcare and Family Services shall assure
7 coverage for the cost of treatment of the drug abuse or
8 addiction for pregnant recipients in accordance with the
9 Illinois Medicaid Program in conjunction with the Department of
10 Human Services.

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

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

1 Neither the Department of Healthcare and Family Services
2 nor the Department of Human Services shall sanction the
3 recipient solely on the basis of her substance abuse.

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

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

22 The sponsor must negotiate formal written contracts with
23 medical providers for physician services, inpatient and
24 outpatient hospital care, home health services, treatment for
25 alcoholism and substance abuse, and other services determined
26 necessary by the Illinois Department by rule for delivery by

1 Partnerships. Physician services must include prenatal and
2 obstetrical care. The Illinois Department shall reimburse
3 medical services delivered by Partnership providers to clients
4 in target areas according to provisions of this Article and the
5 Illinois Health Finance Reform Act, except that:

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

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

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

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

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

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

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

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

1 The rules and regulations of the Illinois Department shall
2 require that a written statement including the required opinion
3 of a physician shall accompany any claim for reimbursement for
4 abortions, or induced miscarriages or premature births. This
5 statement shall indicate what procedures were used in providing
6 such medical services.

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

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

1 to its information technology platforms are implemented.

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

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

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

1 penalty.

2 The Department has the discretion to limit the conditional
3 enrollment period for vendors based upon category of risk of
4 the vendor.

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

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

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

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

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

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

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

24 For claims for services rendered during a period for which
25 a recipient received retroactive eligibility, claims must be
26 filed within 180 days after the Department determines the

1 applicant is eligible. For claims for which the Illinois
2 Department is not the primary payer, claims must be submitted
3 to the Illinois Department within 180 days after the final
4 adjudication by the primary payer.

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

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

26 To the extent consistent with applicable information and

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

14 The Illinois Department shall enter into agreements with
15 State agencies and departments, and is authorized to enter into
16 agreements with federal agencies and departments, under which
17 such agencies and departments shall share data necessary for
18 medical assistance program integrity functions and oversight.
19 The Illinois Department shall develop, in cooperation with
20 other State departments and agencies, and in compliance with
21 applicable federal laws and regulations, appropriate and
22 effective methods to share such data. At a minimum, and to the
23 extent necessary to provide data sharing, the Illinois
24 Department shall enter into agreements with State agencies and
25 departments, and is authorized to enter into agreements with
26 federal agencies and departments, including but not limited to:

1 the Secretary of State; the Department of Revenue; the
2 Department of Public Health; the Department of Human Services;
3 and the Department of Financial and Professional Regulation.

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

18 The Illinois Department shall establish policies,
19 procedures, standards and criteria by rule for the acquisition,
20 repair and replacement of orthotic and prosthetic devices and
21 durable medical equipment. Such rules shall provide, but not be
22 limited to, the following services: (1) immediate repair or
23 replacement of such devices by recipients; and (2) rental,
24 lease, purchase or lease-purchase of durable medical equipment
25 in a cost-effective manner, taking into consideration the
26 recipient's medical prognosis, the extent of the recipient's

1 needs, and the requirements and costs for maintaining such
2 equipment. Subject to prior approval, such rules shall enable a
3 recipient to temporarily acquire and use alternative or
4 substitute devices or equipment pending repairs or
5 replacements of any device or equipment previously authorized
6 for such recipient by the Department.

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

1 providers access to eligibility scores for individuals with an
2 admission date who are seeking or receiving services from the
3 long term care provider. In order to select the minimum level
4 of care eligibility criteria, the Governor shall establish a
5 workgroup that includes affected agency representatives and
6 stakeholders representing the institutional and home and
7 community-based long term care interests. This Section shall
8 not restrict the Department from implementing lower level of
9 care eligibility criteria for community-based services in
10 circumstances where federal approval has been granted.
11 Individuals with a score of 29 or higher based on the
12 determination of need (DON) assessment tool shall be eligible
13 to receive institutional and home and community-based long term
14 care services until such time that the State receives federal
15 approval and implements an updated assessment tool, and those
16 individuals are found to be ineligible under that updated
17 assessment tool. Anyone determined to be ineligible for
18 services due to the updated assessment tool shall continue to
19 be eligible for services for at least one year following that
20 determination and must be reassessed no earlier than 11 months
21 after that determination. The Department must adopt rules
22 through the regular rulemaking process regarding the updated
23 assessment tool, and shall not adopt emergency or peremptory
24 rules regarding the updated assessment tool. The State shall
25 not implement an updated assessment tool that causes more than
26 1% of then-current recipients to lose eligibility. No

1 individual receiving care in an institutional setting shall be
2 involuntarily discharged as the result of the updated
3 assessment tool until a transition plan has been developed by
4 the Department on Aging or its designee and all care identified
5 in the transition plan is available to the resident immediately
6 upon discharge.

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

14 The Illinois Department shall report annually to the
15 General Assembly, no later than the second Friday in April of
16 1979 and each year thereafter, in regard to:

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

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

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

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

25 The period covered by each report shall be the 3 years
26 ending on the June 30 prior to the report. The report shall

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

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

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

23 Because kidney transplantation can be an appropriate, cost
24 effective alternative to renal dialysis when medically
25 necessary and notwithstanding the provisions of Section 1-11 of
26 this Code, beginning October 1, 2014, the Department shall

1 cover kidney transplantation for noncitizens with end-stage
2 renal disease who are not eligible for comprehensive medical
3 benefits, who meet the residency requirements of Section 5-3 of
4 this Code, and who would otherwise meet the financial
5 requirements of the appropriate class of eligible persons under
6 Section 5-2 of this Code. To qualify for coverage of kidney
7 transplantation, such person must be receiving emergency renal
8 dialysis services covered by the Department. Providers under
9 this Section shall be prior approved and certified by the
10 Department to perform kidney transplantation and the services
11 under this Section shall be limited to services associated with
12 kidney transplantation.

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

24 On or after July 1, 2015, opioid antagonists prescribed for
25 the treatment of an opioid overdose, including the medication
26 product, administration devices, and any pharmacy fees related

1 to the dispensing and administration of the opioid antagonist,
2 shall be covered under the medical assistance program for
3 persons who are otherwise eligible for medical assistance under
4 this Article. As used in this Section, "opioid antagonist"
5 means a drug that binds to opioid receptors and blocks or
6 inhibits the effect of opioids acting on those receptors,
7 including, but not limited to, naloxone hydrochloride or any
8 other similarly acting drug approved by the U.S. Food and Drug
9 Administration.

10 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
11 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
12 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
13 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
14 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-433, eff.
15 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

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

17 Sec. 5-5. Medical services. The Illinois Department, by
18 rule, shall determine the quantity and quality of and the rate
19 of reimbursement for the medical assistance for which payment
20 will be authorized, and the medical services to be provided,
21 which may include all or part of the following: (1) inpatient
22 hospital services; (2) outpatient hospital services; (3) other
23 laboratory and X-ray services; (4) skilled nursing home
24 services; (5) physicians' services whether furnished in the
25 office, the patient's home, a hospital, a skilled nursing home,

1 or elsewhere; (6) medical care, or any other type of remedial
2 care furnished by licensed practitioners; (7) home health care
3 services; (8) private duty nursing service; (9) clinic
4 services; (10) dental services, including prevention and
5 treatment of periodontal disease and dental caries disease for
6 pregnant women, provided by an individual licensed to practice
7 dentistry or dental surgery; for purposes of this item (10),
8 "dental services" means diagnostic, preventive, or corrective
9 procedures provided by or under the supervision of a dentist in
10 the practice of his or her profession; (11) physical therapy
11 and related services; (12) prescribed drugs, dentures, and
12 prosthetic devices; and eyeglasses prescribed by a physician
13 skilled in the diseases of the eye, or by an optometrist,
14 whichever the person may select; (13) other diagnostic,
15 screening, preventive, and rehabilitative services, including
16 to ensure that the individual's need for intervention or
17 treatment of mental disorders or substance use disorders or
18 co-occurring mental health and substance use disorders is
19 determined using a uniform screening, assessment, and
20 evaluation process inclusive of criteria, for children and
21 adults; for purposes of this item (13), a uniform screening,
22 assessment, and evaluation process refers to a process that
23 includes an appropriate evaluation and, as warranted, a
24 referral; "uniform" does not mean the use of a singular
25 instrument, tool, or process that all must utilize; (14)
26 transportation and such other expenses as may be necessary;

1 (15) medical treatment of sexual assault survivors, as defined
2 in Section 1a of the Sexual Assault Survivors Emergency
3 Treatment Act, for injuries sustained as a result of the sexual
4 assault, including examinations and laboratory tests to
5 discover evidence which may be used in criminal proceedings
6 arising from the sexual assault; (16) the diagnosis and
7 treatment of sickle cell anemia; and (17) any other medical
8 care, and any other type of remedial care recognized under the
9 laws of this State, but not including abortions, or induced
10 miscarriages or premature births, unless, in the opinion of a
11 physician, such procedures are necessary for the preservation
12 of the life of the woman seeking such treatment, or except an
13 induced premature birth intended to produce a live viable child
14 and such procedure is necessary for the health of the mother or
15 her unborn child. The Illinois Department, by rule, shall
16 prohibit any physician from providing medical assistance to
17 anyone eligible therefor under this Code where such physician
18 has been found guilty of performing an abortion procedure in a
19 wilful and wanton manner upon a woman who was not pregnant at
20 the time such abortion procedure was performed. The term "any
21 other type of remedial care" shall include nursing care and
22 nursing home service for persons who rely on treatment by
23 spiritual means alone through prayer for healing.

24 Notwithstanding any other provision of this Section, a
25 comprehensive tobacco use cessation program that includes
26 purchasing prescription drugs or prescription medical devices

1 approved by the Food and Drug Administration shall be covered
2 under the medical assistance program under this Article for
3 persons who are otherwise eligible for assistance under this
4 Article.

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

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

1 Department or the MCE in which the individual is enrolled for
2 payment and shall be reimbursed at the Department's or the
3 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

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

1 this provision.

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

5 The Department of Healthcare and Family Services must
6 provide coverage and reimbursement for amino acid-based
7 elemental formulas, regardless of delivery method, for the
8 diagnosis and treatment of (i) eosinophilic disorders and (ii)
9 short bowel syndrome when the prescribing physician has issued
10 a written order stating that the amino acid-based elemental
11 formula is medically necessary.

12 The Illinois Department shall authorize the provision of,
13 and shall authorize payment for, screening by low-dose
14 mammography for the presence of occult breast cancer for women
15 35 years of age or older who are eligible for medical
16 assistance under this Article, as follows:

17 (A) A baseline mammogram for women 35 to 39 years of
18 age.

19 (B) An annual mammogram for women 40 years of age or
20 older.

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

26 (D) A comprehensive ultrasound screening of an entire

1 breast or breasts if a mammogram demonstrates
2 heterogeneous or dense breast tissue, when medically
3 necessary as determined by a physician licensed to practice
4 medicine in all of its branches.

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

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

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

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

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

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

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

22 Subject to federal approval, the Department shall
23 establish a rate methodology for mammography at federally
24 qualified health centers and other encounter-rate clinics.
25 These clinics or centers may also collaborate with other
26 hospital-based mammography facilities. By January 1, 2016, the

1 Department shall report to the General Assembly on the status
2 of the provision set forth in this paragraph.

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

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

18 The Department shall devise a means of case-managing or
19 patient navigation for beneficiaries diagnosed with breast
20 cancer. This program shall initially operate as a pilot program
21 in areas of the State with the highest incidence of mortality
22 related to breast cancer. At least one pilot program site shall
23 be in the metropolitan Chicago area and at least one site shall
24 be outside the metropolitan Chicago area. On or after July 1,
25 2016, the pilot program shall be expanded to include one site
26 in western Illinois, one site in southern Illinois, one site in

1 central Illinois, and 4 sites within metropolitan Chicago. An
2 evaluation of the pilot program shall be carried out measuring
3 health outcomes and cost of care for those served by the pilot
4 program compared to similarly situated patients who are not
5 served by the pilot program.

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

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

26 All medical providers providing medical assistance to

1 pregnant women under this Code shall receive information from
2 the Department on the availability of services under the Drug
3 Free Families with a Future or any comparable program providing
4 case management services for addicted women, including
5 information on appropriate referrals for other social services
6 that may be needed by addicted women in addition to treatment
7 for addiction.

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

16 Neither the Department of Healthcare and Family Services
17 nor the Department of Human Services shall sanction the
18 recipient solely on the basis of her substance abuse.

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

1 procedures to the Illinois Department.

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

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

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

26 (2) The Department may elect to consider and negotiate

1 financial incentives to encourage the development of
2 Partnerships and the efficient delivery of medical care.

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

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

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

25 The Department shall apply for a waiver from the United
26 States Health Care Financing Administration to allow for the

1 implementation of Partnerships under this Section.

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

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

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

22 Notwithstanding any other law to the contrary, the Illinois
23 Department shall, within 365 days after July 22, 2013 (the
24 effective date of Public Act 98-104), establish procedures to
25 permit skilled care facilities licensed under the Nursing Home
26 Care Act to submit monthly billing claims for reimbursement

1 purposes. Following development of these procedures, the
2 Department shall, by July 1, 2016, test the viability of the
3 new system and implement any necessary operational or
4 structural changes to its information technology platforms in
5 order to allow for the direct acceptance and payment of nursing
6 home claims.

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

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

26 The Illinois Department may require that all dispensers of

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

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

17 The Department has the discretion to limit the conditional
18 enrollment period for vendors based upon category of risk of
19 the vendor.

20 Prior to enrollment and during the conditional enrollment
21 period in the medical assistance program, all vendors shall be
22 subject to enhanced oversight, screening, and review based on
23 the risk of fraud, waste, and abuse that is posed by the
24 category of risk of the vendor. The Illinois Department shall
25 establish the procedures for oversight, screening, and review,
26 which may include, but need not be limited to: criminal and

1 financial background checks; fingerprinting; license,
2 certification, and authorization verifications; unscheduled or
3 unannounced site visits; database checks; prepayment audit
4 reviews; audits; payment caps; payment suspensions; and other
5 screening as required by federal or State law.

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

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

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

1 complete.

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

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

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

13 For claims for services rendered during a period for which
14 a recipient received retroactive eligibility, claims must be
15 filed within 180 days after the Department determines the
16 applicant is eligible. For claims for which the Illinois
17 Department is not the primary payer, claims must be submitted
18 to the Illinois Department within 180 days after the final
19 adjudication by the primary payer.

20 In the case of long term care facilities, within 5 days of
21 receipt by the facility of required prescreening information,
22 data for new admissions shall be entered into the Medical
23 Electronic Data Interchange (MEDI) or the Recipient
24 Eligibility Verification (REV) System or successor system, and
25 within 15 days of receipt by the facility of required
26 prescreening information, admission documents shall be

1 submitted through MEDI or REV or shall be submitted directly to
2 the Department of Human Services using required admission
3 forms. Effective September 1, 2014, admission documents,
4 including all prescreening information, must be submitted
5 through MEDI or REV. Confirmation numbers assigned to an
6 accepted transaction shall be retained by a facility to verify
7 timely submittal. Once an admission transaction has been
8 completed, all resubmitted claims following prior rejection
9 are subject to receipt no later than 180 days after the
10 admission transaction has been completed.

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

15 To the extent consistent with applicable information and
16 privacy, security, and disclosure laws, State and federal
17 agencies and departments shall provide the Illinois Department
18 access to confidential and other information and data necessary
19 to perform eligibility and payment verifications and other
20 Illinois Department functions. This includes, but is not
21 limited to: information pertaining to licensure;
22 certification; earnings; immigration status; citizenship; wage
23 reporting; unearned and earned income; pension income;
24 employment; supplemental security income; social security
25 numbers; National Provider Identifier (NPI) numbers; the
26 National Practitioner Data Bank (NPDB); program and agency

1 exclusions; taxpayer identification numbers; tax delinquency;
2 corporate information; and death records.

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

19 Beginning in fiscal year 2013, the Illinois Department
20 shall set forth a request for information to identify the
21 benefits of a pre-payment, post-adjudication, and post-edit
22 claims system with the goals of streamlining claims processing
23 and provider reimbursement, reducing the number of pending or
24 rejected claims, and helping to ensure a more transparent
25 adjudication process through the utilization of: (i) provider
26 data verification and provider screening technology; and (ii)

1 clinical code editing; and (iii) pre-pay, pre- or
2 post-adjudicated predictive modeling with an integrated case
3 management system with link analysis. Such a request for
4 information shall not be considered as a request for proposal
5 or as an obligation on the part of the Illinois Department to
6 take any action or acquire any products or services.

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

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 on Aging, to
25 effect the following: (i) intake procedures and common
26 eligibility criteria for those persons who are receiving

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

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

22 The Illinois Department shall develop and operate, in
23 cooperation with other State Departments and agencies and in
24 compliance with applicable federal laws and regulations,
25 appropriate and effective systems of health care evaluation and
26 programs for monitoring of utilization of health care services

1 and facilities, as it affects persons eligible for medical
2 assistance under this Code.

3 The Illinois Department shall report annually to the
4 General Assembly, no later than the second Friday in April of
5 1979 and each year thereafter, in regard to:

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

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

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

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

14 The period covered by each report shall be the 3 years
15 ending on the June 30 prior to the report. The report shall
16 include suggested legislation for consideration by the General
17 Assembly. The filing of one copy of the report with the
18 Speaker, one copy with the Minority Leader and one copy with
19 the Clerk of the House of Representatives, one copy with the
20 President, one copy with the Minority Leader and one copy with
21 the Secretary of the Senate, one copy with the Legislative
22 Research Unit, and such additional copies with the State
23 Government Report Distribution Center for the General Assembly
24 as is required under paragraph (t) of Section 7 of the State
25 Library Act shall be deemed sufficient to comply with this
26 Section.

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

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

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

1 kidney transplantation.

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

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

25 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
26 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.

1 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
2 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
3 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section
4 99 of P.A. 99-407 for its effective date); 99-433, eff.
5 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

6 (305 ILCS 5/5-5.01a)

7 Sec. 5-5.01a. Supportive living facilities program. The
8 Department shall establish and provide oversight for a program
9 of supportive living facilities that seek to promote resident
10 independence, dignity, respect, and well-being in the most
11 cost-effective manner.

12 A supportive living facility is either a free-standing
13 facility or a distinct physical and operational entity within a
14 nursing facility. A supportive living facility integrates
15 housing with health, personal care, and supportive services and
16 is a designated setting that offers residents their own
17 separate, private, and distinct living units.

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

22 Beginning July 1, 2014, subject to federal approval, the
23 Medicaid rates for supportive living facilities shall be equal
24 to the supportive living facility Medicaid rate effective on
25 June 30, 2014 increased by 8.85%. Once the assessment imposed

1 at Article V-G of this Code is determined to be a permissible
2 tax under Title XIX of the Social Security Act, the Department
3 shall increase the Medicaid rates for supportive living
4 facilities effective on July 1, 2014 by 9.09%. The Department
5 shall apply this increase retroactively to coincide with the
6 imposition of the assessment in Article V-G of this Code in
7 accordance with the approval for federal financial
8 participation by the Centers for Medicare and Medicaid
9 Services.

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

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

22 Individuals with a score of 29 or higher based on the
23 determination of need (DON) assessment tool shall be eligible
24 to receive institutional and home and community-based long term
25 care services until such time that the State receives federal
26 approval and implements an updated assessment tool, and those

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

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

19 Section 95. No acceleration or delay. Where this Act makes
20 changes in a statute that is represented in this Act by text
21 that is not yet or no longer in effect (for example, a Section
22 represented by multiple versions), the use of that text does
23 not accelerate or delay the taking effect of (i) the changes
24 made by this Act or (ii) provisions derived from any other
25 Public Act.

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