

1 AN ACT concerning public aid.

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

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

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

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

- 18 (a) (blank);
19 (b) (blank);
20 (c) home care aide services;
21 (d) personal assistant services;
22 (e) adult day services;
23 (f) home-delivered meals;

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

15 Individuals who meet the following criteria shall have

16 equal access to services under the Community Care Program: ~~The~~

17 ~~Department shall establish eligibility standards for such~~

18 ~~services.~~

19 (a) are 60 years old or older;

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

21 (c) are residents of Illinois;

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

23 non-exempt assets do not include home, car, or personal

24 furnishings; and

25 (e) have an assessed need for long term care, as

26 provided in this Section, and are at risk for nursing

1 facility placement as measured by the determination of need
2 assessment tool or a future updated assessment tool.

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

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

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

1 1% of then-current recipients to lose eligibility.

2 Service cost maximums shall be set at levels no lower than
3 the service cost maximums that were in effect as of January 1,
4 2016. Service cost maximums shall be increased accordingly to
5 reflect any rate increases.

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

11 The Department shall, in conjunction with the Department of
12 Public Aid (now Department of Healthcare and Family Services),
13 seek appropriate amendments under Sections 1915 and 1924 of the
14 Social Security Act. The purpose of the amendments shall be to
15 extend eligibility for home and community based services under
16 Sections 1915 and 1924 of the Social Security Act to persons
17 who transfer to or for the benefit of a spouse those amounts of
18 income and resources allowed under Section 1924 of the Social
19 Security Act. Subject to the approval of such amendments, the
20 Department shall extend the provisions of Section 5-4 of the
21 Illinois Public Aid Code to persons who, but for the provision
22 of home or community-based services, would require the level of
23 care provided in an institution, as is provided for in federal
24 law. Those persons no longer found to be eligible for receiving
25 noninstitutional services due to changes in the eligibility
26 criteria shall be given 45 days notice prior to actual

1 termination. Those persons receiving notice of termination may
2 contact the Department and request the determination be
3 appealed at any time during the 45 day notice period. The
4 target population identified for the purposes of this Section
5 are persons age 60 and older with an identified service need.
6 Priority shall be given to those who are at imminent risk of
7 institutionalization. The services shall be provided to
8 eligible persons age 60 and older to the extent that the cost
9 of the services together with the other personal maintenance
10 expenses of the persons are reasonably related to the standards
11 established for care in a group facility appropriate to the
12 person's condition. These non-institutional services, pilot
13 projects or experimental facilities may be provided as part of
14 or in addition to those authorized by federal law or those
15 funded and administered by the Department of Human Services.
16 The Departments of Human Services, Healthcare and Family
17 Services, Public Health, Veterans' Affairs, and Commerce and
18 Economic Opportunity and other appropriate agencies of State,
19 federal and local governments shall cooperate with the
20 Department on Aging in the establishment and development of the
21 non-institutional services. The Department shall require an
22 annual audit from all personal assistant and home care aide
23 vendors contracting with the Department under this Section. The
24 annual audit shall assure that each audited vendor's procedures
25 are in compliance with Department's financial reporting
26 guidelines requiring an administrative and employee wage and

1 benefits cost split as defined in administrative rules. The
2 audit is a public record under the Freedom of Information Act.
3 The Department shall execute, relative to the nursing home
4 prescreening project, written inter-agency agreements with the
5 Department of Human Services and the Department of Healthcare
6 and Family Services, to effect the following: (1) intake
7 procedures and common eligibility criteria for those persons
8 who are receiving non-institutional services; and (2) the
9 establishment and development of non-institutional services in
10 areas of the State where they are not currently available or
11 are undeveloped. On and after July 1, 1996, all nursing home
12 prescreenings for individuals 60 years of age or older shall be
13 conducted by the Department.

14 As part of the Department on Aging's routine training of
15 case managers and case manager supervisors, the Department may
16 include information on family futures planning for persons who
17 are age 60 or older and who are caregivers of their adult
18 children with developmental disabilities. The content of the
19 training shall be at the Department's discretion.

20 The Department is authorized to establish a system of
21 recipient copayment for services provided under this Section,
22 such copayment to be based upon the recipient's ability to pay
23 but in no case to exceed the actual cost of the services
24 provided. Additionally, any portion of a person's income which
25 is equal to or less than the federal poverty standard shall not
26 be considered by the Department in determining the copayment.

1 The level of such copayment shall be adjusted whenever
2 necessary to reflect any change in the officially designated
3 federal poverty standard.

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

1 this Section shall be claimed for recovery from the deceased
2 spouse's estate. "Homestead", as used in this paragraph, means
3 the dwelling house and contiguous real estate occupied by a
4 surviving spouse or relative, as defined by the rules and
5 regulations of the Department of Healthcare and Family
6 Services, regardless of the value of the property.

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

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

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

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

23 (4) ensuring that the determination of need tool is
24 accurate in determining the participants' level of need; to
25 achieve this, the Department, in conjunction with the Older
26 Adult Services Advisory Committee, shall institute a study

1 of the relationship between the Determination of Need
2 scores, level of need, service cost maximums, and the
3 development and utilization of service plans no later than
4 May 1, 2008; findings and recommendations shall be
5 presented to the Governor and the General Assembly no later
6 than January 1, 2009; recommendations shall include all
7 needed changes to the service cost maximums schedule and
8 additional covered services;

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

12 (A) bathing;

13 (B) grooming;

14 (C) toileting;

15 (D) nail care;

16 (E) transferring;

17 (F) respiratory services;

18 (G) exercise; or

19 (H) positioning;

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

26 (7) ensuring that the State may access maximum federal

1 matching funds by seeking approval for the Centers for
2 Medicare and Medicaid Services for modifications to the
3 State's home and community based services waiver and
4 additional waiver opportunities, including applying for
5 enrollment in the Balance Incentive Payment Program by May
6 1, 2013, in order to maximize federal matching funds; this
7 shall include, but not be limited to, modification that
8 reflects all changes in the Community Care Program services
9 and all increases in the services cost maximum;

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

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

21 (10) working in conjunction with Care Coordination
22 Units, the Department of Healthcare and Family Services,
23 the Department of Human Services, Community Care Program
24 providers, and other stakeholders to make improvements to
25 the Medicaid claiming processes and the Medicaid
26 enrollment procedures or requirements as needed,

1 including, but not limited to, specific policy changes or
2 rules to improve the up-front enrollment of participants in
3 the Medicaid program and specific policy changes or rules
4 to insure more prompt submission of bills to the federal
5 government to secure maximum federal matching dollars as
6 promptly as possible; the Department on Aging shall have at
7 least 3 meetings with stakeholders by January 1, 2014 in
8 order to address these improvements;

9 (11) requiring home care service providers to comply
10 with the rounding of hours worked provisions under the
11 federal Fair Labor Standards Act (FLSA) and as set forth in
12 29 CFR 785.48(b) by May 1, 2013;

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

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

22 By January 1, 2009 or as soon after the end of the Cash and
23 Counseling Demonstration Project as is practicable, the
24 Department may, based on its evaluation of the demonstration
25 project, promulgate rules concerning personal assistant
26 services, to include, but need not be limited to,

1 qualifications, employment screening, rights under fair labor
2 standards, training, fiduciary agent, and supervision
3 requirements. All applicants shall be subject to the provisions
4 of the Health Care Worker Background Check Act.

5 The Department shall develop procedures to enhance
6 availability of services on evenings, weekends, and on an
7 emergency basis to meet the respite needs of caregivers.
8 Procedures shall be developed to permit the utilization of
9 services in successive blocks of 24 hours up to the monthly
10 maximum established by the Department. Workers providing these
11 services shall be appropriately trained.

12 Beginning on the effective date of this amendatory Act of
13 1991, no person may perform chore/housekeeping and home care
14 aide services under a program authorized by this Section unless
15 that person has been issued a certificate of pre-service to do
16 so by his or her employing agency. Information gathered to
17 effect such certification shall include (i) the person's name,
18 (ii) the date the person was hired by his or her current
19 employer, and (iii) the training, including dates and levels.
20 Persons engaged in the program authorized by this Section
21 before the effective date of this amendatory Act of 1991 shall
22 be issued a certificate of all pre- and in-service training
23 from his or her employer upon submitting the necessary
24 information. The employing agency shall be required to retain
25 records of all staff pre- and in-service training, and shall
26 provide such records to the Department upon request and upon

1 termination of the employer's contract with the Department. In
2 addition, the employing agency is responsible for the issuance
3 of certifications of in-service training completed to their
4 employees.

5 The Department is required to develop a system to ensure
6 that persons working as home care aides and personal assistants
7 receive increases in their wages when the federal minimum wage
8 is increased by requiring vendors to certify that they are
9 meeting the federal minimum wage statute for home care aides
10 and personal assistants. An employer that cannot ensure that
11 the minimum wage increase is being given to home care aides and
12 personal assistants shall be denied any increase in
13 reimbursement costs.

14 The Community Care Program Advisory Committee is created in
15 the Department on Aging. The Director shall appoint individuals
16 to serve in the Committee, who shall serve at their own
17 expense. Members of the Committee must abide by all applicable
18 ethics laws. The Committee shall advise the Department on
19 issues related to the Department's program of services to
20 prevent unnecessary institutionalization. The Committee shall
21 meet on a bi-monthly basis and shall serve to identify and
22 advise the Department on present and potential issues affecting
23 the service delivery network, the program's clients, and the
24 Department and to recommend solution strategies. Persons
25 appointed to the Committee shall be appointed on, but not
26 limited to, their own and their agency's experience with the

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

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

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

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

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

24 Those persons previously found eligible for receiving
25 non-institutional services whose services were discontinued
26 under the Emergency Budget Act of Fiscal Year 1992, and who do

1 not meet the eligibility standards in effect on or after July
2 1, 1992, shall remain ineligible on and after July 1, 1992.
3 Those persons previously not required to cost-share and who
4 were required to cost-share effective March 1, 1992, shall
5 continue to meet cost-share requirements on and after July 1,
6 1992. Beginning July 1, 1992, all clients will be required to
7 meet eligibility, cost-share, and other requirements and will
8 have services discontinued or altered when they fail to meet
9 these requirements.

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

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

19 The Department shall require, as a condition of
20 eligibility, enrollment in the medical assistance program
21 under Article V of the Illinois Public Aid Code (i) beginning
22 August 1, 2013, if the Auditor General has reported that the
23 Department has failed to comply with the reporting requirements
24 of Section 2-27 of the Illinois State Auditing Act; or (ii)
25 beginning June 1, 2014, if the Auditor General has reported
26 that the Department has not undertaken the required actions

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

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

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

22 The Department shall provide a bi-monthly report on the
23 progress of the Community Care Program reforms set forth in
24 this amendatory Act of the 98th General Assembly to the
25 Governor, the Speaker of the House of Representatives, the
26 Minority Leader of the House of Representatives, the President

1 of the Senate, and the Minority Leader of the Senate.

2 The Department shall conduct a quarterly review of Care
3 Coordination Unit performance and adherence to service
4 guidelines. The quarterly review shall be reported to the
5 Speaker of the House of Representatives, the Minority Leader of
6 the House of Representatives, the President of the Senate, and
7 the Minority Leader of the Senate. The Department shall collect
8 and report longitudinal data on the performance of each care
9 coordination unit. Nothing in this paragraph shall be construed
10 to require the Department to identify specific care
11 coordination units.

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

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

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

1 eff. 7-27-15.)

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

4 (20 ILCS 2405/3) (from Ch. 23, par. 3434)

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

7 (a) To co-operate with the federal government in the
8 administration of the provisions of the federal Rehabilitation
9 Act of 1973, as amended, of the Workforce Investment Act of
10 1998, and of the federal Social Security Act to the extent and
11 in the manner provided in these Acts.

12 (b) To prescribe and supervise such courses of vocational
13 training and provide such other services as may be necessary
14 for the habilitation and rehabilitation of persons with one or
15 more disabilities, including the administrative activities
16 under subsection (e) of this Section, and to co-operate with
17 State and local school authorities and other recognized
18 agencies engaged in habilitation, rehabilitation and
19 comprehensive rehabilitation services; and to cooperate with
20 the Department of Children and Family Services regarding the
21 care and education of children with one or more disabilities.

22 (c) (Blank).

23 (d) To report in writing, to the Governor, annually on or
24 before the first day of December, and at such other times and

1 in such manner and upon such subjects as the Governor may
2 require. The annual report shall contain (1) a statement of the
3 existing condition of comprehensive rehabilitation services,
4 habilitation and rehabilitation in the State; (2) a statement
5 of suggestions and recommendations with reference to the
6 development of comprehensive rehabilitation services,
7 habilitation and rehabilitation in the State; and (3) an
8 itemized statement of the amounts of money received from
9 federal, State and other sources, and of the objects and
10 purposes to which the respective items of these several amounts
11 have been devoted.

12 (e) (Blank).

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

- 19 (1) personal assistant services;
20 (2) homemaker services;
21 (3) home-delivered meals;
22 (4) adult day care services;
23 (5) respite care;
24 (6) home modification or assistive equipment;
25 (7) home health services;
26 (8) electronic home response;

- 1 (9) brain injury behavioral/cognitive services;
- 2 (10) brain injury habilitation;
- 3 (11) brain injury pre-vocational services; or
- 4 (12) brain injury supported employment.

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

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.

12 Service cost maximums shall be set at levels no lower than
13 the service cost maximums that were in effect as of January 1,
14 2016. Service cost maximums shall be increased accordingly to
15 reflect any rate increases.

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

1 and equitable manner. Services identical to those offered by
2 the Department on Aging shall be paid at the same rate.

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

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

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

25 The Department shall execute, relative to nursing home
26 prescreening, as authorized by Section 4.03 of the Illinois Act

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

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

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

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

24 The Department shall submit an annual report on programs
25 and services provided under this Section. The report shall be
26 filed with the Governor and the General Assembly on or before

1 March 30 each year.

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

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

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

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

25 (j) (Blank).

26 (k) (Blank).

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

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

1 the General Assembly, and other persons and for reasons as the
2 Director designates by rule. Disclosure by the Director may be
3 only in accordance with other applicable law.

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

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

7 (210 ILCS 45/3-402) (from Ch. 111 1/2, par. 4153-402)

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

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

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

16 (b) When the transfer or discharge is mandated by the
17 physical safety of other residents, the facility staff, or
18 facility visitors, as documented in the clinical record.
19 The Department shall be notified prior to any such
20 involuntary transfer or discharge. The Department shall
21 immediately offer transfer, or discharge and relocation
22 assistance to residents transferred or discharged under
23 this subparagraph (b), and the Department may place
24 relocation teams as provided in Section 3-419 of this Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 Notwithstanding any other provision of this Code and
25 subject to federal approval, the Department may adopt rules to
26 allow a dentist who is volunteering his or her service at no

1 cost to render dental services through an enrolled
2 not-for-profit health clinic without the dentist personally
3 enrolling as a participating provider in the medical assistance
4 program. A not-for-profit health clinic shall include a public
5 health clinic or Federally Qualified Health Center or other
6 enrolled provider, as determined by the Department, through
7 which dental services covered under this Section are performed.
8 The Department shall establish a process for payment of claims
9 for reimbursement for covered dental services rendered under
10 this provision.

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

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

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

26 (A) A baseline mammogram for women 35 to 39 years of

1 age.

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

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

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

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

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

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

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

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

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

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

26 Subject to federal approval, the Department shall

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

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

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

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

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

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

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

1 addiction for pregnant recipients in accordance with the
2 Illinois Medicaid Program in conjunction with the Department of
3 Human Services.

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

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

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

23 The Illinois Department shall establish such regulations
24 governing the dispensing of health services under this Article
25 as it shall deem appropriate. The Department should seek the
26 advice of formal professional advisory committees appointed by

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

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

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

25 (1) Physicians participating in a Partnership and
26 providing certain services, which shall be determined by

1 the Illinois Department, to persons in areas covered by the
2 Partnership may receive an additional surcharge for such
3 services.

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

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

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

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

1 Practice Act of 1987 without discriminating between service
2 providers.

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

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

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

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

26 Notwithstanding any other law to the contrary, the Illinois

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

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

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

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

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

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

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

24 Prior to enrollment and during the conditional enrollment
25 period in the medical assistance program, all vendors shall be
26 subject to enhanced oversight, screening, and review based on

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

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

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

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

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

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

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

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

24 In the case of long term care facilities, within 5 days of
25 receipt by the facility of required prescreening information,
26 data for new admissions shall be entered into the Medical

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

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

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

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

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

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

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

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

26 The Department shall execute, relative to the nursing home

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

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

26 The Illinois Department shall develop and operate, in

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

7 The Illinois Department shall report annually to the
8 General Assembly, no later than the second Friday in April of
9 1979 and each year thereafter, in regard to:

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

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

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

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

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

1 Government Report Distribution Center for the General Assembly
2 as is required under paragraph (t) of Section 7 of the State
3 Library Act shall be deemed sufficient to comply with this
4 Section.

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

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

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

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

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

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

1 other similarly acting drug approved by the U.S. Food and Drug
2 Administration.

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

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

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

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

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

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

24 Notwithstanding any other provision of this Code, the
25 Illinois Department may not require, as a condition of payment
26 for any laboratory test authorized under this Article, that a

1 physician's handwritten signature appear on the laboratory
2 test order form. The Illinois Department may, however, impose
3 other appropriate requirements regarding laboratory test order
4 documentation.

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

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

1 operated by the Department of Human Services as successor to
2 the Department of Public Aid:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 The Department shall convene an expert panel including
26 representatives of hospitals, free-standing mammography

1 facilities, and doctors, including radiologists, to establish
2 quality standards for mammography.

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

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

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

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

1 outreach and patient navigation to optimize these reminders and
2 shall establish a methodology for evaluating their
3 effectiveness and modifying the methodology based on the
4 evaluation.

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

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

25 The Department shall require all networks of care to
26 develop a means either internally or by contract with experts

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

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

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

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

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

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

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

1 shall develop qualifications for sponsors of Partnerships.
2 Nothing in this Section shall be construed to require that the
3 sponsor organization be a medical organization.

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

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

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

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

26 Medical providers shall be required to meet certain

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

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

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

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

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

1 effective date of Public Act 83-1439) ~~this amendatory Act of~~
2 ~~1984~~, the Illinois Department shall establish a current list of
3 acquisition costs for all prosthetic devices and any other
4 items recognized as medical equipment and supplies
5 reimbursable under this Article and shall update such list on a
6 quarterly basis, except that the acquisition costs of all
7 prescription drugs shall be updated no less frequently than
8 every 30 days as required by Section 5-5.12.

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

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

26 Notwithstanding any other law to the contrary, the Illinois

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

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

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

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

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

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

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

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

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

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

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

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

1 Department initiates the monthly billing process.

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

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

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

1 completed, all resubmitted claims following prior rejection
2 are subject to receipt no later than 180 days after the
3 admission transaction has been completed.

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

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

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

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

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

26 The Illinois Department shall establish policies,

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

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

1 ~~term care; if and only if federal approval is not granted, the~~
2 ~~Department may, in conjunction with other affected agencies,~~
3 ~~implement utilization controls or changes in benefit packages~~
4 ~~to effectuate a similar savings amount for this population; and~~
5 ~~(iv)~~ no later than July 1, 2013, minimum level of care
6 eligibility criteria for institutional and home and
7 community-based long term care; and (iv) ~~(v)~~ no later than
8 October 1, 2013, establish procedures to permit long term care
9 providers access to eligibility scores for individuals with an
10 admission date who are seeking or receiving services from the
11 long term care provider. In order to select the minimum level
12 of care eligibility criteria, the Governor shall establish a
13 workgroup that includes affected agency representatives and
14 stakeholders representing the institutional and home and
15 community-based long term care interests. This Section shall
16 not restrict the Department from implementing lower level of
17 care eligibility criteria for community-based services in
18 circumstances where federal approval has been granted.
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. No
9 individual receiving care in an institutional setting shall be
10 involuntarily discharged as the result of the updated
11 assessment tool until a transition plan has been developed by
12 the Department on Aging or its designee and all care identified
13 in the transition plan is available to the resident immediately
14 upon discharge.

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

22 The Illinois Department shall report annually to the
23 General Assembly, no later than the second Friday in April of
24 1979 and each year thereafter, in regard to:

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

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

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

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

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

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

26 On and after July 1, 2012, the Department shall reduce any

1 rate of reimbursement for services or other payments or alter
2 any methodologies authorized by this Code to reduce any rate of
3 reimbursement for services or other payments in accordance with
4 Section 5-5e.

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

21 Notwithstanding any other provision of this Code to the
22 contrary, on or after July 1, 2015, all FDA approved forms of
23 medication assisted treatment prescribed for the treatment of
24 alcohol dependence or treatment of opioid dependence shall be
25 covered under both fee for service and managed care medical
26 assistance programs for persons who are otherwise eligible for

1 medical assistance under this Article and shall not be subject
2 to any (1) utilization control, other than those established
3 under the American Society of Addiction Medicine patient
4 placement criteria, (2) prior authorization mandate, or (3)
5 lifetime restriction limit mandate.

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

18 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
19 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
20 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
21 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
22 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section
23 99 of P.A. 99-407 for its effective date); 99-433, eff.
24 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

25 (305 ILCS 5/5-5.01a)

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

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

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

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

1 participation by the Centers for Medicare and Medicaid
2 Services.

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

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

15 Individuals with a score of 29 or higher based on the
16 determination of need (DON) assessment tool shall be eligible
17 to receive institutional and home and community-based long term
18 care services until such time that the State receives federal
19 approval and implements an updated assessment tool, and those
20 individuals are found to be ineligible under that updated
21 assessment tool. Anyone determined to be ineligible for
22 services due to the updated assessment tool shall continue to
23 be eligible for services for at least one year following that
24 determination and must be reassessed no earlier than 11 months
25 after that determination. The Department must adopt rules
26 through the regular rulemaking process regarding the updated

1 assessment tool, and shall not adopt emergency or peremptory
2 rules regarding the updated assessment tool. The State shall
3 not implement an updated assessment tool that causes more than
4 1% of then-current recipients to lose eligibility. No
5 individual receiving care in an institutional setting shall be
6 involuntarily discharged as the result of the updated
7 assessment tool until a transition plan has been developed by
8 the Department on Aging or its designee and all care identified
9 in the transition plan is available to the resident immediately
10 upon discharge.

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

12 Section 95. No acceleration or delay. Where this Act makes
13 changes in a statute that is represented in this Act by text
14 that is not yet or no longer in effect (for example, a Section
15 represented by multiple versions), the use of that text does
16 not accelerate or delay the taking effect of (i) the changes
17 made by this Act or (ii) provisions derived from any other
18 Public Act.

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