AN ACT concerning public aid.

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

Section 3. The Illinois Administrative Procedure Act is amended by changing Section 5-70 as follows:

(5 ILCS 100/5-70) (from Ch. 127, par. 1005-70)

Sec. 5-70. Form and publication of notices.

(a) The Secretary of State may prescribe reasonable rules concerning the form of documents to be filed with the Secretary of State and may refuse to accept for filing certified copies that do not comply with the rules. In addition, the Secretary of State shall publish and maintain the Illinois Register and may prescribe reasonable rules setting forth the manner in which agencies shall submit notices required by this Act for publication in the Illinois Register. The Illinois Register shall be published at least once each week on the same day (unless that day is an official State holiday, in which case the Illinois Register shall be published on the next following business day) and sent to subscribers who subscribe for the publication with the Secretary of State. The Secretary of State may charge a subscription price to subscribers that covers mailing and publication costs.

(b) The Secretary of State shall accept for publication in

the Illinois Register all Pollution Control Board documents, including but not limited to Board opinions, the results of Board determinations concerning adjusted standards proceedings, notices of petitions for individual adjusted standards, results of Board determinations concerning the necessity for economic impact studies, restricted status lists, hearing notices, and any other documents related to the activities of the Pollution Control Board that the Board deems appropriate for publication.

(c) The Secretary of State shall accept for publication in the Illinois Register notices initiated by the Department of Healthcare and Family Services in its capacity as the designate Title XIX single State agency pursuant to the requirements found at 42 CFR 447.205, and any other documents related to the activities of the programs administered by the Department of Healthcare and Family Services that the Department deems appropriate for publication.

(Source: P.A. 87-823.)

(20 ILCS 10/Act rep.)

Section 4. The Illinois Welfare and Rehabilitation Services Planning Act is repealed.

Section 6. The State Finance Act is amended by changing Sections 5.573 and 6z-58 as follows:

(30 ILCS 105/5.573)

Sec. 5.573. The Medical Interagency Program ~~Family Care~~ Fund.

(Source: P.A. 95-331, eff. 8-21-07.)

(30 ILCS 105/6z-58)

Sec. 6z-58. The Medical Interagency Program ~~Family Care~~ Fund.

(a) There is created in the State treasury the Medical Interagency Program ~~Family Care~~ Fund. Interest earned by the Fund shall be credited to the Fund.

(b) The Fund is created for the purposes of receiving, investing, and distributing moneys in accordance with (i) an approved State plan or waiver under the Social Security Act ~~resulting from the Family Care waiver request submitted by the Illinois Department of Public Aid on February 15, 2002~~ and (ii) an interagency agreement between the Department of Healthcare and Family Services (formerly Department of Public Aid) and another agency of State government. The Fund shall consist of:

(1) All federal financial participation moneys received pursuant to expenditures from the Fund ~~the approved waiver, except for moneys received pursuant to expenditures for medical services by the Department of Healthcare and Family Services (formerly Department of Public Aid) from any other fund~~; and

(2) All other moneys received by the Fund from any

source, including interest thereon.

(c) Subject to appropriation, the moneys in the Fund shall be disbursed for reimbursement of medical services and other costs associated with persons receiving such services:

(1) under programs administered by the Department of Healthcare and Family Services (formerly Department of Public Aid); and

(2) pursuant to an interagency agreement, under programs administered by another agency of State government.

(Source: P.A. 95-331, eff. 8-21-07.)

Section 10. The Nursing Home Care Act is amended by changing Section 2-201.5 as follows:

(210 ILCS 45/2-201.5)

Sec. 2-201.5. Screening prior to admission.

(a) All persons age 18 or older seeking admission to a nursing facility must be screened to determine the need for nursing facility services prior to being admitted, regardless of income, assets, or funding source. ~~In addition, any person who seeks to become eligible for medical assistance from the Medical Assistance Program under the Illinois Public Aid Code to pay for long term care services while residing in a facility must be screened prior to receiving those benefits.~~ Screening for nursing facility services shall be administered through

procedures established by administrative rule. Screening may be done by agencies other than the Department as established by administrative rule. This Section applies on and after July 1, 1996. No later than October 1, 2010, the Department of Healthcare and Family Services, in collaboration with the Department on Aging, the Department of Human Services, and the Department of Public Health, shall file administrative rules providing for the gathering, during the screening process, of information relevant to determining each person's potential for placing other residents, employees, and visitors at risk of harm.

(a-1) Any screening performed pursuant to subsection (a) of this Section shall include a determination of whether any person is being considered for admission to a nursing facility due to a need for mental health services. For a person who needs mental health services, the screening shall also include an evaluation of whether there is permanent supportive housing, or an array of community mental health services, including but not limited to supported housing, assertive community treatment, and peer support services, that would enable the person to live in the community. The person shall be told about the existence of any such services that would enable the person to live safely and humanely and about available appropriate nursing home services that would enable the person to live safely and humanely, and the person shall be given the assistance necessary to avail himself or herself of any

available services.

(a-2) Pre-screening for persons with a serious mental illness shall be performed by a psychiatrist, a psychologist, a registered nurse certified in psychiatric nursing, a licensed clinical professional counselor, or a licensed clinical social worker, who is competent to (i) perform a clinical assessment of the individual, (ii) certify a diagnosis, (iii) make a determination about the individual's current need for treatment, including substance abuse treatment, and recommend specific treatment, and (iv) determine whether a facility or a community-based program is able to meet the needs of the individual.

For any person entering a nursing facility, the pre-screening agent shall make specific recommendations about what care and services the individual needs to receive, beginning at admission, to attain or maintain the individual's highest level of independent functioning and to live in the most integrated setting appropriate for his or her physical and personal care and developmental and mental health needs. These recommendations shall be revised as appropriate by the pre-screening or re-screening agent based on the results of resident review and in response to changes in the resident's wishes, needs, and interest in transition.

Upon the person entering the nursing facility, the Department of Human Services or its designee shall assist the person in establishing a relationship with a community mental

health agency or other appropriate agencies in order to (i) promote the person's transition to independent living and (ii) support the person's progress in meeting individual goals.

(a-3) The Department of Human Services, by rule, shall provide for a prohibition on conflicts of interest for pre-admission screeners. The rule shall provide for waiver of those conflicts by the Department of Human Services if the Department of Human Services determines that a scarcity of qualified pre-admission screeners exists in a given community and that, absent a waiver of conflicts, an insufficient number of pre-admission screeners would be available. If a conflict is waived, the pre-admission screener shall disclose the conflict of interest to the screened individual in the manner provided for by rule of the Department of Human Services. For the purposes of this subsection, a "conflict of interest" includes, but is not limited to, the existence of a professional or financial relationship between (i) a PAS-MH corporate or a PAS-MH agent and (ii) a community provider or long-term care facility.

(b) In addition to the screening required by subsection (a), a facility, except for those licensed as long term care for under age 22 facilities, shall, within 24 hours after admission, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons age 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant

to subsection (d) of Section 6.09 of the Hospital Licensing Act. Background checks conducted pursuant to this Section shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check, unless the fingerprint check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk which may be established by Departmental rule. A waiver issued pursuant to this Section shall be valid only while the resident is immobile or while the criteria supporting the waiver exist. The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility. If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident.

(c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01, the facility shall do the following:

(1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, in collaboration with the Department of Public

Health, that the resident is an identified offender.

(2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this paragraph (2), any criminal history record information contained in its files.

The facility shall comply with all applicable provisions contained in the Uniform Conviction Information Act.

All name-based and fingerprint-based criminal history record inquiries shall be submitted to the Department of State Police electronically in the form and manner prescribed by the Department of State Police. The Department of State Police may charge the facility a fee for processing name-based and fingerprint-based criminal history record inquiries. The fee shall be deposited into the State Police Services Fund. The fee shall not exceed the actual cost of processing the inquiry.

(d) (Blank).

(e) The Department shall develop and maintain a

de-identified database of residents who have injured facility staff, facility visitors, or other residents, and the attendant circumstances, solely for the purposes of evaluating and improving resident pre-screening and assessment procedures (including the Criminal History Report prepared under Section 2-201.6) and the adequacy of Department requirements concerning the provision of care and services to residents. A resident shall not be listed in the database until a Department survey confirms the accuracy of the listing. The names of persons listed in the database and information that would allow them to be individually identified shall not be made public. Neither the Department nor any other agency of State government may use information in the database to take any action against any individual, licensee, or other entity, unless the Department or agency receives the information independent of this subsection (e). All information collected, maintained, or developed under the authority of this subsection (e) for the purposes of the database maintained under this subsection (e) shall be treated in the same manner as information that is subject to Part 21 of Article VIII of the Code of Civil Procedure.

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

Section 15. The Illinois Public Aid Code is amended by changing Sections 5-2, 5-5, 5-26, 5A-9, 12-4.42, and 12-10.5 as follows:

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

Sec. 5-2. Classes of Persons Eligible. Medical assistance under this Article shall be available to any of the following classes of persons in respect to whom a plan for coverage has been submitted to the Governor by the Illinois Department and approved by him:

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

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

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

(i) their income, as determined by the Illinois Department in accordance with any federal requirements, is equal to or less than 70% in

fiscal year 2001, equal to or less than 85% in fiscal year 2002 and until a date to be determined by the Department by rule, and equal to or less than 100% beginning on the date determined by the Department by rule, of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the same size; or

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

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

permitted by federal law.

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

4. Persons not eligible under any of the preceding paragraphs who fall sick, are injured, or die, not having sufficient money, property or other resources to meet the costs of necessary medical care or funeral and burial expenses.

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

(b) The Illinois Department and the Governor shall provide a plan for coverage of the persons eligible under paragraph 5(a) by April 1, 1990. Such plan shall provide ambulatory prenatal care to pregnant women during a presumptive eligibility period and establish an income eligibility standard that is equal to 133% of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the

same size, provided that costs incurred for medical care are not taken into account in determining such income eligibility.

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

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

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

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

(b) it is appropriate to provide such care outside of an institution, as determined by a physician licensed to practice medicine in all its branches;

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

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

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

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

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

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

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

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

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

10. Participants in the long-term care insurance partnership program established under the Illinois

Long-Term Care Partnership Program Act who meet the qualifications for protection of resources described in Section 15 of that Act.

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

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

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

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

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

12. Subject to federal approval, persons who are eligible for medical assistance coverage under applicable provisions of the federal Social Security Act and the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000. Those eligible persons are defined to include, but not be limited to, the following persons:

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

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

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

In addition to the persons who are eligible for medical

assistance pursuant to subparagraphs (1) and (2) of this paragraph 12, and to be paid from funds appropriated to the Department for its medical programs, any uninsured person as defined by the Department in rules residing in Illinois who is younger than 65 years of age, who has been screened for breast and cervical cancer in accordance with standards and procedures adopted by the Department of Public Health for screening, and who is referred to the Department by the Department of Public Health as being in need of treatment for breast or cervical cancer is eligible for medical assistance benefits that are consistent with the benefits provided to those persons described in subparagraphs (1) and (2). Medical assistance coverage for the persons who are eligible under the preceding sentence is not dependent on federal approval, but federal moneys may be used to pay for services provided under that coverage upon federal approval.

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

14. Subject to the availability of funds for this purpose, the Department may provide coverage under this Article to persons who reside in Illinois who are not eligible under any of the preceding paragraphs and who meet

the income guidelines of paragraph 2(a) of this Section and (i) have an application for asylum pending before the federal Department of Homeland Security or on appeal before a court of competent jurisdiction and are represented either by counsel or by an advocate accredited by the federal Department of Homeland Security and employed by a not-for-profit organization in regard to that application or appeal, or (ii) are receiving services through a federally funded torture treatment center. Medical coverage under this paragraph 14 may be provided for up to 24 continuous months from the initial eligibility date so long as an individual continues to satisfy the criteria of this paragraph 14. If an individual has an appeal pending regarding an application for asylum before the Department of Homeland Security, eligibility under this paragraph 14 may be extended until a final decision is rendered on the appeal. The Department may adopt rules governing the implementation of this paragraph 14.

15. Family Care Eligibility.

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

(b) Eligibility shall be reviewed annually.

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

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

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

(f) Individuals shall have a grace period through 60 ~~30~~ days of coverage to pay the premium.

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

(h) Partial premium payments shall not be refunded.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided,

which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, for children and adults; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which

may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State, but not including abortions, or induced miscarriages or premature births, unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child. The Illinois Department, by rule, shall prohibit any physician from providing medical assistance to anyone eligible therefor under this Code where such physician has been found guilty of performing an abortion procedure in a wilful and wanton manner upon a woman who was not pregnant at the time such abortion procedure was performed. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

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

The Department of Healthcare and Family Services shall provide the following services to persons eligible for assistance under this Article who are participating in education, training or employment programs operated by the Department of Human Services as successor to the Department of Public Aid:

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

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

Notwithstanding any other provision of this Code and subject to federal approval, the Department may adopt rules to allow a dentist who is volunteering his or her service at no cost to render dental services through an enrolled not-for-profit health clinic without the dentist personally enrolling as a participating provider in the medical assistance program. A not-for-profit health clinic shall include a public health clinic or Federally Qualified Health Center or other

enrolled provider, as determined by the Department, through which dental services covered under this Section are performed. The Department shall establish a process for payment of claims for reimbursement for covered dental services rendered under this provision.

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

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

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

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

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

(C) A mammogram at the age and intervals considered medically necessary by the woman's health care provider for

women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.

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

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

On and after July 1, 2008, screening and diagnostic mammography shall be reimbursed at the same rate as the Medicare program's rates, including the increased reimbursement for digital mammography.

The Department shall convene an expert panel including representatives of hospitals, free-standing mammography facilities, and doctors, including radiologists, to establish quality standards. Based on these quality standards, the

Department shall provide for bonus payments to mammography facilities meeting the standards for screening and diagnosis. The bonus payments shall be at least 15% higher than the Medicare rates for mammography.

Subject to federal approval, the Department shall establish a rate methodology for mammography at federally qualified health centers and other encounter-rate clinics. These clinics or centers may also collaborate with other hospital-based mammography facilities.

The Department shall establish a methodology to remind women who are age-appropriate for screening mammography, but who have not received a mammogram within the previous 18 months, of the importance and benefit of screening mammography.

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

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. An evaluation of the

pilot program shall be carried out measuring health outcomes and cost of care for those served by the pilot program compared to similarly situated patients who are not served by the pilot program.

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

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

The Illinois Department, in cooperation with the Departments of Human Services (as successor to the Department

of Alcoholism and Substance Abuse) and Public Health, through a public awareness campaign, may provide information concerning treatment for alcoholism and drug abuse and addiction, prenatal health care, and other pertinent programs directed at reducing the number of drug-affected infants born to recipients of medical assistance.

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

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

Notwithstanding any other provision of law, a health care provider under the medical assistance program may elect, in lieu of receiving direct payment for services provided under that program, to participate in the State Employees Deferred Compensation Plan adopted under Article 24 of the Illinois Pension Code. A health care provider who elects to participate in the plan does not have a cause of action against the State for any damages allegedly suffered by the provider as a result

of any delay by the State in crediting the amount of any contribution to the provider's plan account.

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

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

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

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

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

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

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

The Department shall apply for a waiver from the United

States Health Care Financing Administration to allow for the implementation of Partnerships under this Section.

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be

approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after the effective date of this amendatory Act of 1984, the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

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

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

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

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

Enrollment of a vendor that provides non-emergency medical transportation, defined by the Department by rule, shall be conditional for 180 days. During that time, the Department of Healthcare and Family Services may terminate the vendor's eligibility to participate in the medical assistance program without cause. That termination of eligibility is not subject to the Department's hearing process.

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients without medical authorization; and (2) rental, lease, purchase or

lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of the recipient's needs, and the requirements and costs for maintaining such equipment. Such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department.

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped.

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

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

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

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

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

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

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

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for

whatever reason, is unauthorized.

(Source: P.A. 95-331, eff. 8-21-07; 95-520, eff. 8-28-07; 95-1045, eff. 3-27-09; 96-156, eff. 1-1-10; 96-806, eff. 7-1-10; 96-926, eff. 1-1-11; 96-1000, eff. 7-2-10.)

(305 ILCS 5/5-26)

Sec. 5-26. Federal Family Opportunity Act.

(a) As used in this Section, "the federal Act" means the federal Family Opportunity Act, enacted as part of the Deficit Reduction Act of 2005.

(b) Subject to appropriations for program administration and services, the ~~The~~ Department of Human Services, in conjunction with the Department of Healthcare and Family Services, shall implement the Medical Assistance provisions of the federal Act as soon as possible after the effective date of this amendatory Act of the 95th General Assembly.

(c) As soon as possible after the effective date of this amendatory Act of the 95th General Assembly, the Department of Human Services, in conjunction with the Department of Healthcare and Family Services, shall take all necessary and appropriate steps to try to secure (i) any available federal funds for a demonstration project regarding home and community-based alternatives to psychiatric residential treatment facilities for children, as authorized by the federal Act, and (ii) the location in Illinois of a family-to-family health information center, as authorized by the federal Act.

(Source: P.A. 95-37, eff. 8-10-07.)

(305 ILCS 5/5A-9) (from Ch. 23, par. 5A-9)

Sec. 5A-9. Emergency services audits. The Illinois Department may audit hospital claims for payment for emergency services provided to a recipient who does not require admission as an inpatient. The Illinois Department shall adopt rules that describe how the emergency services audit process will be conducted. These rules shall include, but need not be limited to, the following provisions:

(1) The determination that an emergency medical condition exists shall be based upon the symptoms and condition of the recipient at the time the recipient is initially examined by the hospital emergency department and not upon the final determination of the recipient's actual medical condition.

(2) The Illinois Department or its authorized representative shall meet with the chief executive officer of the hospital, or a person designated by the chief executive officer, upon arrival at the hospital to conduct the audit and before leaving the hospital at the conclusion of the audit. The purpose of the pre-audit meeting shall be to inform the hospital concerning the scope of the audit. The purpose of the post-audit meeting shall be to provide the hospital with the preliminary findings of the audit.

(3) An emergency services audit shall be limited to a

review of records related to services rendered within 6 ~~3~~ years of the date of the audit. The hospital's business and professional records for at least 12 previous calendar months shall be maintained and available for inspection by authorized Illinois Department personnel on the premises of the hospital. Illinois Department personnel shall make requests in writing to inspect records more than 12 months old at least 2 business days in advance of the date they must be produced.

(4) Where the purpose of the audit is to determine the appropriateness of the emergency services provided, any final determination that would result in a denial of or reduction in payment to the hospital shall be made by a physician licensed to practice medicine in all of its branches who is board certified in emergency medicine or by the appropriate health care professionals under the supervision of the physician.

(5) The preliminary audit findings shall be provided to the hospital within 120 days of the date on which the audit conducted on the hospital premises was completed.

(6) The Illinois Department or its designated review agent shall use statistically valid sampling techniques when conducting audits.

(Source: P.A. 87-861.)

(305 ILCS 5/12-4.42)

Sec. 12-4.42 ~~12-4.40~~. Medicaid Revenue Maximization.

(a) Purpose. The General Assembly finds that there is a need to make changes to the administration of services provided by State and local governments in order to maximize federal financial participation.

(b) Definitions. As used in this Section:

"Community Medicaid mental health services" means all mental health services outlined in Section 132 of Title 59 of the Illinois Administrative Code that are funded through DHS, eligible for federal financial participation, and provided by a community-based provider.

"Community-based provider" means an entity enrolled as a provider pursuant to Sections 140.11 and 140.12 of Title 89 of the Illinois Administrative Code and certified to provide community Medicaid mental health services in accordance with Section 132 of Title 59 of the Illinois Administrative Code.

"DCFS" means the Department of Children and Family Services.

"Department" means the Illinois Department of Healthcare and Family Services.

"Developmentally disabled care facility" means an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act, whether public or private and whether organized for profit or not-for-profit, but shall not include any facility operated by the State.

"Developmentally disabled care provider" means a person

conducting, operating, or maintaining a developmentally disabled care facility. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

"DHS" means the Illinois Department of Human Services.

"Hospital" means an institution, place, building, or agency located in this State that is licensed as a general acute hospital by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.

"Long term care facility" means (i) a skilled nursing or intermediate long term care facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code, and (ii) a part of a hospital in which skilled or intermediate long term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided; except that the term "long term care facility" does not include a facility operated solely as an intermediate care facility for the mentally retarded within the meaning of Title

XIX of the Social Security Act.

"Long term care provider" means (i) a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long term care facility or (ii) a hospital provider that provides skilled or intermediate long term care services within the meaning of Title XVIII or XIX of the Social Security Act. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

"State-operated developmentally disabled care facility" means an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act operated by the State.

(c) Administration and deposit of Revenues. The Department shall coordinate the implementation of changes required by this amendatory Act of the 96th General Assembly amongst the various State and local government bodies that administer programs referred to in this Section.

Revenues generated by program changes mandated by any provision in this Section, less reasonable administrative costs associated with the implementation of these program changes, <u>which would otherwise be deposited into the General</u>

Revenue Fund shall be deposited into the Healthcare Provider Relief Fund.

The Department shall issue a report to the General Assembly detailing the implementation progress of this amendatory Act of the 96th General Assembly as a part of the Department's Medical Programs annual report for fiscal years 2010 and 2011.

(d) Acceleration of payment vouchers. To the extent practicable and permissible under federal law, the Department shall create all vouchers for long term care facilities and developmentally disabled care facilities for dates of service in the month in which the enhanced federal medical assistance percentage (FMAP) originally set forth in the American Recovery and Reinvestment Act (ARRA) expires and for dates of service in the month prior to that month and shall, no later than the 15th of the month in which the enhanced FMAP expires, submit these vouchers to the Comptroller for payment.

The Department of Human Services shall create the necessary documentation for State-operated developmentally disabled care facilities so that the necessary data for all dates of service before the expiration of the enhanced FMAP originally set forth in the ARRA can be adjudicated by the Department no later than the 15th of the month in which the enhanced FMAP expires.

(e) Billing of DHS community Medicaid mental health services. No later than July 1, 2011, community Medicaid mental health services provided by a community-based provider must be billed directly to the Department.

(f) DCFS Medicaid services. The Department shall work with DCFS to identify existing programs, pending qualifying services, that can be converted in an economically feasible manner to Medicaid in order to secure federal financial revenue.

(g) Third Party Liability recoveries. The Department shall contract with a vendor to support the Department in coordinating benefits for Medicaid enrollees. The scope of work shall include, at a minimum, the identification of other insurance for Medicaid enrollees and the recovery of funds paid by the Department when another payer was liable. The vendor may be paid a percentage of actual cash recovered when practical and subject to federal law.

(h) Public health departments. The Department shall identify unreimbursed costs for persons covered by Medicaid who are served by the Chicago Department of Public Health.

The Department shall assist the Chicago Department of Public Health in determining total unreimbursed costs associated with the provision of healthcare services to Medicaid enrollees.

The Department shall determine and draw the maximum allowable federal matching dollars associated with the cost of Chicago Department of Public Health services provided to Medicaid enrollees.

(i) Acceleration of hospital-based payments. The Department shall, by the 10th day of the month in which the

enhanced FMAP originally set forth in the ARRA expires, create vouchers for all State fiscal year 2011 hospital payments exempt from the prompt payment requirements of the ARRA. The Department shall submit these vouchers to the Comptroller for payment.

(Source: P.A. 96-1405, eff. 7-29-10; revised 9-9-10.)

(305 ILCS 5/12-10.5)

Sec. 12-10.5. Medical Special Purposes Trust Fund.

(a) The Medical Special Purposes Trust Fund ("the Fund") is created. Any grant, gift, donation, or legacy of money or securities that the Department of Healthcare and Family Services is authorized to receive under Section 12-4.18 or Section 12-4.19, and that is dedicated for functions connected with the administration of any medical program administered by the Department, shall be deposited into the Fund. All federal moneys received by the Department as reimbursement for disbursements authorized to be made from the Fund shall also be deposited into the Fund. In addition, federal moneys received on account of State expenditures made in connection with obtaining compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) shall be deposited into the Fund.

(b) No moneys received from a service provider or a governmental or private entity that is enrolled with the Department as a provider of medical services shall be deposited

into the Fund.

(c) Disbursements may be made from the Fund for the purposes connected with the grants, gifts, donations, or legacies deposited into the Fund, including, but not limited to, medical quality assessment projects, eligibility population studies, medical information systems evaluations, and other administrative functions that assist the Department in fulfilling its health care mission under any medical program administered by the Department ~~the Illinois Public Aid Code and the Children's Health Insurance Program Act~~.

(Source: P.A. 95-331, eff. 8-21-07.)

(305 ILCS 5/5-2.4 rep.)

(305 ILCS 5/9A-9.5 rep.)

Section 20. The Illinois Public Aid Code is amended by repealing Sections 5-2.4 and 9A-9.5.

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

INDEX

Statutes amended in order of appearance