Sen. Daniel Biss

Filed: 5/9/2017

1 AMENDMENT TO SENATE BILL 399

2 AMENDMENT NO. ______. Amend Senate Bill 399 by replacing
3 everything after the enacting clause with the following:

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

6 (20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)
7 Sec. 4.02. Community Care Program. The Department shall
8 establish a program of services to prevent unnecessary
9 institutionalization of persons age 60 and older in need of
10 long term care or who are established as persons who suffer
11 from Alzheimer's disease or a related disorder under the
12 Alzheimer's Disease Assistance Act, thereby enabling them to
13 remain in their own homes or in other living arrangements. Such
14 preventive services, which may be coordinated with other
15 programs for the aged and monitored by area agencies on aging
16 in cooperation with the Department, may include, but are not

limited to, any or all of the following:

(a) (blank);

(b) (blank);

(c) home care aide services;

(d) personal assistant services;

(e) adult day services;

(f) home-delivered meals;

(g) education in self-care;

(h) personal care services;

(i) adult day health services;

(j) habilitation services;

(k) respite care;

(k-5) community reintegration services;

(k-6) flexible senior services;

(k-7) medication management;

(k-8) emergency home response;

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

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

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

(a) are 60 years old or older;

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

(c) are residents of Illinois;

(d) have non-exempt assets of $17,500 or less; non-exempt assets do not include home, car, or personal furnishings; and

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

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

Need for long term care shall be determined as follows: Individuals with a score of 29 or higher based on the determination of need (DON) assessment tool shall be eligible to receive institutional and home and community-based long term care services until the State receives federal approval and implements an updated assessment tool, and those individuals are found to be ineligible under that updated assessment tool. Anyone determined to be ineligible for services due to the updated assessment tool shall continue to be eligible for

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

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

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

18 The Department shall not: (i) adopt any rule that restricts
19 eligibility under the Community Care Program to persons who
20 qualify for medical assistance under Article V of the Illinois
21 Public Aid Code; or (ii) establish, by rule, a separate program
22 of home and community-based long term care services for persons
23 who are otherwise eligible for services under the Community
24 Care Program but who do not qualify for medical assistance
25 under Article V of the Illinois Public Aid Code.

26 The Department shall, in conjunction with the Department of

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

1 person's condition. These non-institutional services, pilot
2 projects or experimental facilities may be provided as part of
3 or in addition to those authorized by federal law or those
4 funded and administered by the Department of Human Services.
5 The Departments of Human Services, Healthcare and Family
6 Services, Public Health, Veterans' Affairs, and Commerce and
7 Economic Opportunity and other appropriate agencies of State,
8 federal and local governments shall cooperate with the
9 Department on Aging in the establishment and development of the
10 non-institutional services. The Department shall require an
11 annual audit from all personal assistant and home care aide
12 vendors contracting with the Department under this Section. The
13 annual audit shall assure that each audited vendor's procedures
14 are in compliance with Department's financial reporting
15 guidelines requiring an administrative and employee wage and
16 benefits cost split as defined in administrative rules. The
17 audit is a public record under the Freedom of Information Act.
18 The Department shall execute, relative to the nursing home
19 prescreening project, written inter-agency agreements with the
20 Department of Human Services and the Department of Healthcare
21 and Family Services, to effect the following: (1) intake
22 procedures and common eligibility criteria for those persons
23 who are receiving non-institutional services; and (2) the
24 establishment and development of non-institutional services in
25 areas of the State where they are not currently available or
26 are undeveloped. On and after July 1, 1996, all nursing home

1 prescreenings for individuals 60 years of age or older shall be
2 conducted by the Department.

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

9 The Department is authorized to establish a system of
10 recipient copayment for services provided under this Section,
11 such copayment to be based upon the recipient's ability to pay
12 but in no case to exceed the actual cost of the services
13 provided. Additionally, any portion of a person's income which
14 is equal to or less than the federal poverty standard shall not
15 be considered by the Department in determining the copayment.
16 The level of such copayment shall be adjusted whenever
17 necessary to reflect any change in the officially designated
18 federal poverty standard. The Department shall not increase
19 copayment levels to the levels that were in effect on January
20 1, 2016, except to make an adjustment for inflation.

21 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 increase the effectiveness of the
25 existing Community Care Program by:

26 (1) ensuring that in-home services included in the care

1 plan are available on evenings and weekends;
2 (2) ensuring that care plans contain the services that
3 eligible participants need based on the number of days in a
4 month, not limited to specific blocks of time, as
5 identified by the comprehensive assessment tool selected
6 by the Department for use statewide, not to exceed the
7 total monthly service cost maximum allowed for each
8 service; the Department shall develop administrative rules
9 to implement this item (2);
10 (3) ensuring that the participants have the right to
11 choose the services contained in their care plan and to
12 direct how those services are provided, based on
13 administrative rules established by the Department;
14 (4) ensuring that the determination of need tool is
15 accurate in determining the participants' level of need; to
16 achieve this, the Department, in conjunction with the Older
17 Adult Services Advisory Committee, shall institute a study
18 of the relationship between the Determination of Need
19 scores, level of need, service cost maximums, and the
20 development and utilization of service plans no later than
21 May 1, 2008; findings and recommendations shall be
22 presented to the Governor and the General Assembly no later
23 than January 1, 2009; recommendations shall include all
24 needed changes to the service cost maximums schedule and
25 additional covered services;
26 (5) ensuring that homemakers can provide personal care

services that may or may not involve contact with clients, including but not limited to:

(A) bathing;

(B) grooming;

(C) toileting;

(D) nail care;

(E) transferring;

(F) respiratory services;

(G) exercise; or

(H) positioning;

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

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

1 (8) ensuring that the determination of need tool
2 accurately reflects the service needs of individuals with
3 Alzheimer's disease and related dementia disorders;
4 (9) ensuring that services are authorized accurately
5 and consistently for the Community Care Program (CCP); the
6 Department shall implement a Service Authorization policy
7 directive; the purpose shall be to ensure that eligibility
8 and services are authorized accurately and consistently in
9 the CCP program; the policy directive shall clarify service
10 authorization guidelines to Care Coordination Units and
11 Community Care Program providers no later than May 1, 2013;
12 (10) working in conjunction with Care Coordination
13 Units, the Department of Healthcare and Family Services,
14 the Department of Human Services, Community Care Program
15 providers, and other stakeholders to make improvements to
16 the Medicaid claiming processes and the Medicaid
17 enrollment procedures or requirements as needed,
18 including, but not limited to, specific policy changes or
19 rules to improve the up-front enrollment of participants in
20 the Medicaid program and specific policy changes or rules
21 to insure more prompt submission of bills to the federal
22 government to secure maximum federal matching dollars as
23 promptly as possible; the Department on Aging shall have at
24 least 3 meetings with stakeholders by January 1, 2014 in
25 order to address these improvements;
26 (11) requiring home care service providers to comply

with the rounding of hours worked provisions under the federal Fair Labor Standards Act (FLSA) and as set forth in 29 CFR 785.48(b) by May 1, 2013;

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

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

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

The Department shall develop procedures to enhance availability of services on evenings, weekends, and on an emergency basis to meet the respite needs of caregivers. Procedures shall be developed to permit the utilization of services in successive blocks of 24 hours up to the monthly

maximum established by the Department. Workers providing these services shall be appropriately trained.

Beginning on the effective date of this amendatory Act of 1991, no person may perform chore/housekeeping and home care aide services under a program authorized by this Section unless that person has been issued a certificate of pre-service to do so by his or her employing agency. Information gathered to effect such certification shall include (i) the person's name, (ii) the date the person was hired by his or her current employer, and (iii) the training, including dates and levels. Persons engaged in the program authorized by this Section before the effective date of this amendatory Act of 1991 shall be issued a certificate of all pre- and in-service training from his or her employer upon submitting the necessary information. The employing agency shall be required to retain records of all staff pre- and in-service training, and shall provide such records to the Department upon request and upon termination of the employer's contract with the Department. In addition, the employing agency is responsible for the issuance of certifications of in-service training completed to their employees.

The Department is required to develop a system to ensure that persons working as home care aides and personal assistants receive increases in their wages when the federal minimum wage is increased by requiring vendors to certify that they are meeting the federal minimum wage statute for home care aides

1 and personal assistants. An employer that cannot ensure that
2 the minimum wage increase is being given to home care aides and
3 personal assistants shall be denied any increase in
4 reimbursement costs.

5 The Community Care Program Advisory Committee is created in
6 the Department on Aging. The Director shall appoint individuals
7 to serve in the Committee, who shall serve at their own
8 expense. Members of the Committee must abide by all applicable
9 ethics laws. The Committee shall advise the Department on
10 issues related to the Department's program of services to
11 prevent unnecessary institutionalization. The Committee shall
12 meet on a bi-monthly basis and shall serve to identify and
13 advise the Department on present and potential issues affecting
14 the service delivery network, the program's clients, and the
15 Department and to recommend solution strategies. Persons
16 appointed to the Committee shall be appointed on, but not
17 limited to, their own and their agency's experience with the
18 program, geographic representation, and willingness to serve.
19 The Director shall appoint members to the Committee to
20 represent provider, advocacy, policy research, and other
21 constituencies committed to the delivery of high quality home
22 and community-based services to older adults. Representatives
23 shall be appointed to ensure representation from community care
24 providers including, but not limited to, adult day service
25 providers, homemaker providers, case coordination and case
26 management units, emergency home response providers, statewide

1 trade or labor unions that represent home care aides and direct
2 care staff, area agencies on aging, adults over age 60,
3 membership organizations representing older adults, and other
4 organizational entities, providers of care, or individuals
5 with demonstrated interest and expertise in the field of home
6 and community care as determined by the Director.

7 Nominations may be presented from any agency or State
8 association with interest in the program. The Director, or his
9 or her designee, shall serve as the permanent co-chair of the
10 advisory committee. One other co-chair shall be nominated and
11 approved by the members of the committee on an annual basis.
12 Committee members' terms of appointment shall be for 4 years
13 with one-quarter of the appointees' terms expiring each year. A
14 member shall continue to serve until his or her replacement is
15 named. The Department shall fill vacancies that have a
16 remaining term of over one year, and this replacement shall
17 occur through the annual replacement of expiring terms. The
18 Director shall designate Department staff to provide technical
19 assistance and staff support to the committee. Department
20 representation shall not constitute membership of the
21 committee. All Committee papers, issues, recommendations,
22 reports, and meeting memoranda are advisory only. The Director,
23 or his or her designee, shall make a written report, as
24 requested by the Committee, regarding issues before the
25 Committee.

26 The Department on Aging and the Department of Human

1 Services shall cooperate in the development and submission of
2 an annual report on programs and services provided under this
3 Section. Such joint report shall be filed with the Governor and
4 the General Assembly on or before September 30 each year.

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

15 Those persons previously found eligible for receiving
16 non-institutional services whose services were discontinued
17 under the Emergency Budget Act of Fiscal Year 1992, and who do
18 not meet the eligibility standards in effect on or after July
19 1, 1992, shall remain ineligible on and after July 1, 1992.
20 Those persons previously not required to cost-share and who
21 were required to cost-share effective March 1, 1992, shall
22 continue to meet cost-share requirements on and after July 1,
23 1992. Beginning July 1, 1992, all clients will be required to
24 meet eligibility, cost-share, and other requirements and will
25 have services discontinued or altered when they fail to meet
26 these requirements.

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

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

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

~~The Department shall delay Community Care Program services until an applicant is determined eligible for medical assistance under Article V of the Illinois Public Aid Code (i) beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has~~

~~reported that the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-27 of the Illinois State Auditing Act.~~

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

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

The Department shall conduct a quarterly review of Care Coordination Unit performance and adherence to service guidelines. The quarterly review shall be reported to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate. The Department shall collect and report longitudinal data on the performance of each care coordination unit. Nothing in this paragraph shall be construed

1 to require the Department to identify specific care
2 coordination units.
3 In regard to community care providers, failure to comply
4 with Department on Aging policies shall be cause for
5 disciplinary action, including, but not limited to,
6 disqualification from serving Community Care Program clients.
7 Each provider, upon submission of any bill or invoice to the
8 Department for payment for services rendered, shall include a
9 notarized statement, under penalty of perjury pursuant to
10 Section 1-109 of the Code of Civil Procedure, that the provider
11 has complied with all Department policies.
12 The Director of the Department on Aging shall make
13 information available to the State Board of Elections as may be
14 required by an agreement the State Board of Elections has
15 entered into with a multi-state voter registration list
16 maintenance system.
17 (Source: P.A. 98-8, eff. 5-3-13; 98-1171, eff. 6-1-15; 99-143,
18 eff. 7-27-15.)

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

21 (20 ILCS 2405/3) (from Ch. 23, par. 3434)
22 Sec. 3. Powers and duties. The Department shall have the
23 powers and duties enumerated herein:
24 (a) To co-operate with the federal government in the

1 administration of the provisions of the federal Rehabilitation
2 Act of 1973, as amended, of the Workforce Investment Act of
3 1998, and of the federal Social Security Act to the extent and
4 in the manner provided in these Acts.

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

15 (c) (Blank).

16 (d) To report in writing, to the Governor, annually on or
17 before the first day of December, and at such other times and
18 in such manner and upon such subjects as the Governor may
19 require. The annual report shall contain (1) a statement of the
20 existing condition of comprehensive rehabilitation services,
21 habilitation and rehabilitation in the State; (2) a statement
22 of suggestions and recommendations with reference to the
23 development of comprehensive rehabilitation services,
24 habilitation and rehabilitation in the State; and (3) an
25 itemized statement of the amounts of money received from
26 federal, State and other sources, and of the objects and

purposes to which the respective items of these several amounts have been devoted.

(e) (Blank).

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

(1) personal assistant services;

(2) homemaker services;

(3) home-delivered meals;

(4) adult day care services;

(5) respite care;

(6) home modification or assistive equipment;

(7) home health services;

(8) electronic home response;

(9) brain injury behavioral/cognitive services;

(10) brain injury habilitation;

(11) brain injury pre-vocational services; or

(12) brain injury supported employment.

The Department shall establish eligibility standards for such services taking into consideration the unique economic and social needs of the population for whom they are to be provided. Such eligibility standards may be based on the recipient's ability to pay for services; provided, however,

1 that any portion of a person's income that is equal to or less
2 than the "protected income" level shall not be considered by
3 the Department in determining eligibility. The "protected
4 income" level shall be determined by the Department, shall
5 never be less than the federal poverty standard, and shall be
6 adjusted each year to reflect changes in the Consumer Price
7 Index For All Urban Consumers as determined by the United
8 States Department of Labor. The standards must provide that a
9 person may not have more than $10,000 in assets to be eligible
10 for the services, and the Department may increase or decrease
11 the asset limitation by rule. The Department may not decrease
12 the asset level below $10,000.

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

implement an updated assessment tool that causes more than 1% of then-current recipients to lose eligibility.

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

The services shall be provided, as established by the Department by rule, to eligible persons to prevent unnecessary or premature institutionalization, to the extent that the cost of the services, together with the other personal maintenance expenses of the persons, are reasonably related to the standards established for care in a group facility appropriate to their condition. These non-institutional services, pilot projects or experimental facilities may be provided as part of or in addition to those authorized by federal law or those funded and administered by the Illinois Department on Aging. The Department shall set rates and fees for services in a fair and equitable manner. Services identical to those offered by the Department on Aging shall be paid at the same rate.

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

Solely for the purposes of coverage under the Illinois Public Labor Relations Act (5 ILCS 315/), personal assistants

1 providing services under the Department's Home Services
2 Program shall be considered to be public employees and the
3 State of Illinois shall be considered to be their employer as
4 of the effective date of this amendatory Act of the 93rd
5 General Assembly, but not before. Solely for the purposes of
6 coverage under the Illinois Public Labor Relations Act, home
7 care and home health workers who function as personal
8 assistants and individual maintenance home health workers and
9 who also provide services under the Department's Home Services
10 Program shall be considered to be public employees, no matter
11 whether the State provides such services through direct
12 fee-for-service arrangements, with the assistance of a managed
13 care organization or other intermediary, or otherwise, and the
14 State of Illinois shall be considered to be the employer of
15 those persons as of January 29, 2013 (the effective date of
16 Public Act 97-1158), but not before except as otherwise
17 provided under this subsection (f). The State shall engage in
18 collective bargaining with an exclusive representative of home
19 care and home health workers who function as personal
20 assistants and individual maintenance home health workers
21 working under the Home Services Program concerning their terms
22 and conditions of employment that are within the State's
23 control. Nothing in this paragraph shall be understood to limit
24 the right of the persons receiving services defined in this
25 Section to hire and fire home care and home health workers who
26 function as personal assistants and individual maintenance

home health workers working under the Home Services Program or to supervise them within the limitations set by the Home Services Program. The State shall not be considered to be the employer of home care and home health workers who function as personal assistants and individual maintenance home health workers working under the Home Services Program for any purposes not specifically provided in Public Act 93-204 or Public Act 97-1158, including but not limited to, purposes of vicarious liability in tort and purposes of statutory retirement or health insurance benefits. Home care and home health workers who function as personal assistants and individual maintenance home health workers and who also provide services under the Department's Home Services Program shall not be covered by the State Employees Group Insurance Act of 1971 (5 ILCS 375/).

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

The Department is authorized to establish a system of recipient cost-sharing for services provided under this

1 Section. The cost-sharing shall be based upon the recipient's
2 ability to pay for services, but in no case shall the
3 recipient's share exceed the actual cost of the services
4 provided. Protected income shall not be considered by the
5 Department in its determination of the recipient's ability to
6 pay a share of the cost of services. The level of cost-sharing
7 shall be adjusted each year to reflect changes in the
8 "protected income" level. The Department shall deduct from the
9 recipient's share of the cost of services any money expended by
10 the recipient for disability-related expenses.

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

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

15 The Department shall submit an annual report on programs
16 and services provided under this Section. The report shall be
17 filed with the Governor and the General Assembly on or before
18 March 30 each year.

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

1 under paragraph (t) of Section 7 of the State Library Act.
2 (g) To establish such subdivisions of the Department as
3 shall be desirable and assign to the various subdivisions the
4 responsibilities and duties placed upon the Department by law.
5 (h) To cooperate and enter into any necessary agreements
6 with the Department of Employment Security for the provision of
7 job placement and job referral services to clients of the
8 Department, including job service registration of such clients
9 with Illinois Employment Security offices and making job
10 listings maintained by the Department of Employment Security
11 available to such clients.
12 (i) To possess all powers reasonable and necessary for the
13 exercise and administration of the powers, duties and
14 responsibilities of the Department which are provided for by
15 law.
16 (j) (Blank).
17 (k) (Blank).
18 (l) To establish, operate and maintain a Statewide Housing
19 Clearinghouse of information on available, government
20 subsidized housing accessible to persons with disabilities and
21 available privately owned housing accessible to persons with
22 disabilities. The information shall include but not be limited
23 to the location, rental requirements, access features and
24 proximity to public transportation of available housing. The
25 Clearinghouse shall consist of at least a computerized database
26 for the storage and retrieval of information and a separate or

shared toll free telephone number for use by those seeking information from the Clearinghouse. Department offices and personnel throughout the State shall also assist in the operation of the Statewide Housing Clearinghouse. Cooperation with local, State and federal housing managers shall be sought and extended in order to frequently and promptly update the Clearinghouse's information.

(m) To assure that the names and case records of persons who received or are receiving services from the Department, including persons receiving vocational rehabilitation, home services, or other services, and those attending one of the Department's schools or other supervised facility shall be confidential and not be open to the general public. Those case records and reports or the information contained in those records and reports shall be disclosed by the Director only to proper law enforcement officials, individuals authorized by a court, the General Assembly or any committee or commission of the General Assembly, and other persons and for reasons as the Director designates by rule. Disclosure by the Director may be only in accordance with other applicable law.

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

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

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

1 Sec. 3-402. Involuntary transfer or discharge.
2 Involuntary transfer or discharge of a resident from a
3 facility shall be preceded by the discussion required under
4 Section 3-408 and by a minimum written notice of 21 days,
5 except in one of the following instances:
6 (a) When an emergency transfer or discharge is ordered
7 by the resident's attending physician because of the
8 resident's health care needs.
9 (b) When the transfer or discharge is mandated by the
10 physical safety of other residents, the facility staff, or
11 facility visitors, as documented in the clinical record.
12 The Department shall be notified prior to any such
13 involuntary transfer or discharge. The Department shall
14 immediately offer transfer, or discharge and relocation
15 assistance to residents transferred or discharged under
16 this subparagraph (b), and the Department may place
17 relocation teams as provided in Section 3-419 of this Act.
18 (c) When an identified offender is within the
19 provisional admission period defined in Section 1-120.3.
20 If the Identified Offender Report and Recommendation
21 prepared under Section 2-201.6 shows that the identified
22 offender poses a serious threat or danger to the physical
23 safety of other residents, the facility staff, or facility
24 visitors in the admitting facility and the facility
25 determines that it is unable to provide a safe environment
26 for the other residents, the facility staff, or facility

1 visitors, the facility shall transfer or discharge the
2 identified offender within 3 days after its receipt of the
3 Identified Offender Report and Recommendation.
4 No individual receiving care in an institutional setting
5 shall be involuntarily discharged as the result of the updated
6 determination of need (DON) assessment tool as provided in
7 Section 5-5 of the Illinois Public Aid Code until a transition
8 plan has been developed by the Department on Aging or its
9 designee and all care identified in the transition plan is
10 available to the resident immediately upon discharge.
11 (Source: P.A. 96-1372, eff. 7-29-10.)

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

14 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)
15 Sec. 5-5. Medical services. The Illinois Department, by
16 rule, shall determine the quantity and quality of and the rate
17 of reimbursement for the medical assistance for which payment
18 will be authorized, and the medical services to be provided,
19 which may include all or part of the following: (1) inpatient
20 hospital services; (2) outpatient hospital services; (3) other
21 laboratory and X-ray services; (4) skilled nursing home
22 services; (5) physicians' services whether furnished in the
23 office, the patient's home, a hospital, a skilled nursing home,
24 or elsewhere; (6) medical care, or any other type of remedial

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

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

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

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

payment and shall be reimbursed at the Department's or the MCE's established rates or rate methodologies for eyeglasses.

On and after July 1, 2012, the Department of Healthcare and Family Services may 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.

1 The Illinois Department, by rule, may distinguish and
2 classify the medical services to be provided only in accordance
3 with the classes of persons designated in Section 5-2.
4 The Department of Healthcare and Family Services must
5 provide coverage and reimbursement for amino acid-based
6 elemental formulas, regardless of delivery method, for the
7 diagnosis and treatment of (i) eosinophilic disorders and (ii)
8 short bowel syndrome when the prescribing physician has issued
9 a written order stating that the amino acid-based elemental
10 formula is medically necessary.
11 The Illinois Department shall authorize the provision of,
12 and shall authorize payment for, screening by low-dose
13 mammography for the presence of occult breast cancer for women
14 35 years of age or older who are eligible for medical
15 assistance under this Article, as follows:
16 (A) A baseline mammogram for women 35 to 39 years of
17 age.
18 (B) An annual mammogram for women 40 years of age or
19 older.
20 (C) A mammogram at the age and intervals considered
21 medically necessary by the woman's health care provider for
22 women under 40 years of age and having a family history of
23 breast cancer, prior personal history of breast cancer,
24 positive genetic testing, or other risk factors.
25 (D) A comprehensive ultrasound screening of an entire
26 breast or breasts if a mammogram demonstrates

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

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

7 All screenings shall include a physical breast exam,
8 instruction on self-examination and information regarding the
9 frequency of self-examination and its value as a preventative
10 tool. For purposes of this Section, "low-dose mammography"
11 means the x-ray examination of the breast using equipment
12 dedicated specifically for mammography, including the x-ray
13 tube, filter, compression device, and image receptor, with an
14 average radiation exposure delivery of less than one rad per
15 breast for 2 views of an average size breast. The term also
16 includes digital mammography and includes breast
17 tomosynthesis. As used in this Section, the term "breast
18 tomosynthesis" means a radiologic procedure that involves the
19 acquisition of projection images over the stationary breast to
20 produce cross-sectional digital three-dimensional images of
21 the breast. If, at any time, the Secretary of the United States
22 Department of Health and Human Services, or its successor
23 agency, promulgates rules or regulations to be published in the
24 Federal Register or publishes a comment in the Federal Register
25 or issues an opinion, guidance, or other action that would
26 require the State, pursuant to any provision of the Patient

1 Protection and Affordable Care Act (Public Law 111-148),
2 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
3 successor provision, to defray the cost of any coverage for
4 breast tomosynthesis outlined in this paragraph, then the
5 requirement that an insurer cover breast tomosynthesis is
6 inoperative other than any such coverage authorized under
7 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
8 the State shall not assume any obligation for the cost of
9 coverage for breast tomosynthesis set forth in this paragraph.
10 On and after January 1, 2016, the Department shall ensure
11 that all networks of care for adult clients of the Department
12 include access to at least one breast imaging Center of Imaging
13 Excellence as certified by the American College of Radiology.
14 On and after January 1, 2012, providers participating in a
15 quality improvement program approved by the Department shall be
16 reimbursed for screening and diagnostic mammography at the same
17 rate as the Medicare program's rates, including the increased
18 reimbursement for digital mammography.
19 The Department shall convene an expert panel including
20 representatives of hospitals, free-standing mammography
21 facilities, and doctors, including radiologists, to establish
22 quality standards for mammography.
23 On and after January 1, 2017, providers participating in a
24 breast cancer treatment quality improvement program approved
25 by the Department shall be reimbursed for breast cancer
26 treatment at a rate that is no lower than 95% of the Medicare

1 program's rates for the data elements included in the breast
2 cancer treatment quality program.
3 The Department shall convene an expert panel, including
4 representatives of hospitals, free standing breast cancer
5 treatment centers, breast cancer quality organizations, and
6 doctors, including breast surgeons, reconstructive breast
7 surgeons, oncologists, and primary care providers to establish
8 quality standards for breast cancer treatment.
9 Subject to federal approval, the Department shall
10 establish a rate methodology for mammography at federally
11 qualified health centers and other encounter-rate clinics.
12 These clinics or centers may also collaborate with other
13 hospital-based mammography facilities. By January 1, 2016, the
14 Department shall report to the General Assembly on the status
15 of the provision set forth in this paragraph.
16 The Department shall establish a methodology to remind
17 women who are age-appropriate for screening mammography, but
18 who have not received a mammogram within the previous 18
19 months, of the importance and benefit of screening mammography.
20 The Department shall work with experts in breast cancer
21 outreach and patient navigation to optimize these reminders and
22 shall establish a methodology for evaluating their
23 effectiveness and modifying the methodology based on the
24 evaluation.
25 The Department shall establish a performance goal for
26 primary care providers with respect to their female patients

1 over age 40 receiving an annual mammogram. This performance
2 goal shall be used to provide additional reimbursement in the
3 form of a quality performance bonus to primary care providers
4 who meet that goal.

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

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

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

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

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

1 the number of drug-affected infants born to recipients of
2 medical assistance.
3 Neither the Department of Healthcare and Family Services
4 nor the Department of Human Services shall sanction the
5 recipient solely on the basis of her substance abuse.
6 The Illinois Department shall establish such regulations
7 governing the dispensing of health services under this Article
8 as it shall deem appropriate. The Department should seek the
9 advice of formal professional advisory committees appointed by
10 the Director of the Illinois Department for the purpose of
11 providing regular advice on policy and administrative matters,
12 information dissemination and educational activities for
13 medical and health care providers, and consistency in
14 procedures to the Illinois Department.
15 The Illinois Department may develop and contract with
16 Partnerships of medical providers to arrange medical services
17 for persons eligible under Section 5-2 of this Code.
18 Implementation of this Section may be by demonstration projects
19 in certain geographic areas. The Partnership shall be
20 represented by a sponsor organization. The Department, by rule,
21 shall develop qualifications for sponsors of Partnerships.
22 Nothing in this Section shall be construed to require that the
23 sponsor organization be a medical organization.
24 The sponsor must negotiate formal written contracts with
25 medical providers for physician services, inpatient and
26 outpatient hospital care, home health services, treatment for

1 alcoholism and substance abuse, and other services determined
2 necessary by the Illinois Department by rule for delivery by
3 Partnerships. Physician services must include prenatal and
4 obstetrical care. The Illinois Department shall reimburse
5 medical services delivered by Partnership providers to clients
6 in target areas according to provisions of this Article and the
7 Illinois Health Finance Reform Act, except that:
8 (1) Physicians participating in a Partnership and
9 providing certain services, which shall be determined by
10 the Illinois Department, to persons in areas covered by the
11 Partnership may receive an additional surcharge for such
12 services.
13 (2) The Department may elect to consider and negotiate
14 financial incentives to encourage the development of
15 Partnerships and the efficient delivery of medical care.
16 (3) Persons receiving medical services through
17 Partnerships may receive medical and case management
18 services above the level usually offered through the
19 medical assistance program.
20 Medical providers shall be required to meet certain
21 qualifications to participate in Partnerships to ensure the
22 delivery of high quality medical services. These
23 qualifications shall be determined by rule of the Illinois
24 Department and may be higher than qualifications for
25 participation in the medical assistance program. Partnership
26 sponsors may prescribe reasonable additional qualifications

1 for participation by medical providers, only with the prior
2 written approval of the Illinois Department.
3 Nothing in this Section shall limit the free choice of
4 practitioners, hospitals, and other providers of medical
5 services by clients. In order to ensure patient freedom of
6 choice, the Illinois Department shall immediately promulgate
7 all rules and take all other necessary actions so that provided
8 services may be accessed from therapeutically certified
9 optometrists to the full extent of the Illinois Optometric
10 Practice Act of 1987 without discriminating between service
11 providers.
12 The Department shall apply for a waiver from the United
13 States Health Care Financing Administration to allow for the
14 implementation of Partnerships under this Section.
15 The Illinois Department shall require health care
16 providers to maintain records that document the medical care
17 and services provided to recipients of Medical Assistance under
18 this Article. Such records must be retained for a period of not
19 less than 6 years from the date of service or as provided by
20 applicable State law, whichever period is longer, except that
21 if an audit is initiated within the required retention period
22 then the records must be retained until the audit is completed
23 and every exception is resolved. The Illinois Department shall
24 require health care providers to make available, when
25 authorized by the patient, in writing, the medical records in a
26 timely fashion to other health care providers who are treating

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

1 less frequently than every 30 days as required by Section
2 5-5.12.
3 The rules and regulations of the Illinois Department shall
4 require that a written statement including the required opinion
5 of a physician shall accompany any claim for reimbursement for
6 abortions, or induced miscarriages or premature births. This
7 statement shall indicate what procedures were used in providing
8 such medical services.
9 Notwithstanding any other law to the contrary, the Illinois
10 Department shall, within 365 days after July 22, 2013 (the
11 effective date of Public Act 98-104), establish procedures to
12 permit skilled care facilities licensed under the Nursing Home
13 Care Act to submit monthly billing claims for reimbursement
14 purposes. Following development of these procedures, the
15 Department shall, by July 1, 2016, test the viability of the
16 new system and implement any necessary operational or
17 structural changes to its information technology platforms in
18 order to allow for the direct acceptance and payment of nursing
19 home claims.
20 Notwithstanding any other law to the contrary, the Illinois
21 Department shall, within 365 days after August 15, 2014 (the
22 effective date of Public Act 98-963), establish procedures to
23 permit ID/DD facilities licensed under the ID/DD Community Care
24 Act and MC/DD facilities licensed under the MC/DD Act to submit
25 monthly billing claims for reimbursement purposes. Following
26 development of these procedures, the Department shall have an

1 additional 365 days to test the viability of the new system and
2 to ensure that any necessary operational or structural changes
3 to its information technology platforms are implemented.

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

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

21 Enrollment of a vendor shall be subject to a provisional
22 period and shall be conditional for one year. During the period
23 of conditional enrollment, the Department may terminate the
24 vendor's eligibility to participate in, or may disenroll the
25 vendor from, the medical assistance program without cause.
26 Unless otherwise specified, such termination of eligibility or

disenrollment is not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

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

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

The Department shall define or specify the following: (i) by provider notice, the "category of risk of the vendor" for each type of vendor, which shall take into account the level of screening applicable to a particular category of vendor under federal law and regulations; (ii) by rule or provider notice, the maximum length of the conditional enrollment period for each category of risk of the vendor; and (iii) by rule, the hearing rights, if any, afforded to a vendor in each category

of risk of the vendor that is terminated or disenrolled during the conditional enrollment period.

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

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

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

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

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

For claims for services rendered during a period for which

1 a recipient received retroactive eligibility, claims must be
2 filed within 180 days after the Department determines the
3 applicant is eligible. For claims for which the Illinois
4 Department is not the primary payer, claims must be submitted
5 to the Illinois Department within 180 days after the final
6 adjudication by the primary payer.

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

24 Claims that are not submitted and received in compliance
25 with the foregoing requirements shall not be eligible for
26 payment under the medical assistance program, and the State

1 shall have no liability for payment of those claims.
2 To the extent consistent with applicable information and
3 privacy, security, and disclosure laws, State and federal
4 agencies and departments shall provide the Illinois Department
5 access to confidential and other information and data necessary
6 to perform eligibility and payment verifications and other
7 Illinois Department functions. This includes, but is not
8 limited to: information pertaining to licensure;
9 certification; earnings; immigration status; citizenship; wage
10 reporting; unearned and earned income; pension income;
11 employment; supplemental security income; social security
12 numbers; National Provider Identifier (NPI) numbers; the
13 National Practitioner Data Bank (NPDB); program and agency
14 exclusions; taxpayer identification numbers; tax delinquency;
15 corporate information; and death records.
16 The Illinois Department shall enter into agreements with
17 State agencies and departments, and is authorized to enter into
18 agreements with federal agencies and departments, under which
19 such agencies and departments shall share data necessary for
20 medical assistance program integrity functions and oversight.
21 The Illinois Department shall develop, in cooperation with
22 other State departments and agencies, and in compliance with
23 applicable federal laws and regulations, appropriate and
24 effective methods to share such data. At a minimum, and to the
25 extent necessary to provide data sharing, the Illinois
26 Department shall enter into agreements with State agencies and

1 departments, and is authorized to enter into agreements with
2 federal agencies and departments, including but not limited to:
3 the Secretary of State; the Department of Revenue; the
4 Department of Public Health; the Department of Human Services;
5 and the Department of Financial and Professional Regulation.
6 Beginning in fiscal year 2013, the Illinois Department
7 shall set forth a request for information to identify the
8 benefits of a pre-payment, post-adjudication, and post-edit
9 claims system with the goals of streamlining claims processing
10 and provider reimbursement, reducing the number of pending or
11 rejected claims, and helping to ensure a more transparent
12 adjudication process through the utilization of: (i) provider
13 data verification and provider screening technology; and (ii)
14 clinical code editing; and (iii) pre-pay, pre- or
15 post-adjudicated predictive modeling with an integrated case
16 management system with link analysis. Such a request for
17 information shall not be considered as a request for proposal
18 or as an obligation on the part of the Illinois Department to
19 take any action or acquire any products or services.
20 The Illinois Department shall establish policies,
21 procedures, standards and criteria by rule for the acquisition,
22 repair and replacement of orthotic and prosthetic devices and
23 durable medical equipment. Such rules shall provide, but not be
24 limited to, the following services: (1) immediate repair or
25 replacement of such devices by recipients; and (2) rental,
26 lease, purchase or lease-purchase of durable medical equipment

1 in a cost-effective manner, taking into consideration the
2 recipient's medical prognosis, the extent of the recipient's
3 needs, and the requirements and costs for maintaining such
4 equipment. Subject to prior approval, such rules shall enable a
5 recipient to temporarily acquire and use alternative or
6 substitute devices or equipment pending repairs or
7 replacements of any device or equipment previously authorized
8 for such recipient by the Department. Notwithstanding any
9 provision of Section 5-5f to the contrary, the Department may,
10 by rule, exempt certain replacement wheelchair parts from prior
11 approval and, for wheelchairs, wheelchair parts, wheelchair
12 accessories, and related seating and positioning items,
13 determine the wholesale price by methods other than actual
14 acquisition costs.

15 The Department shall require, by rule, all providers of
16 durable medical equipment to be accredited by an accreditation
17 organization approved by the federal Centers for Medicare and
18 Medicaid Services and recognized by the Department in order to
19 bill the Department for providing durable medical equipment to
20 recipients. No later than 15 months after the effective date of
21 the rule adopted pursuant to this paragraph, all providers must
22 meet the accreditation requirement.

23 The Department shall execute, relative to the nursing home
24 prescreening project, written inter-agency agreements with the
25 Department of Human Services and the Department on Aging, to
26 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; and (iii) ~~notwithstanding any other provision of law, subject to federal approval, on and after July 1, 2012, an increase in the determination of need (DON) scores from 29 to 37 for applicants for institutional and home and community-based long term care; if and only if federal approval is not granted, the Department may, in conjunction with other affected agencies, implement utilization controls or changes in benefit packages to effectuate a similar savings amount for this population; and (iv)~~ no later than July 1, 2013, minimum level of care eligibility criteria for institutional and home and community-based long term care; and (iv) ~~(v)~~ no later than October 1, 2013, establish procedures to permit long term care providers access to eligibility scores for individuals with an admission date who are seeking or receiving services from the long term care provider. In order to select the minimum level of care eligibility criteria, the Governor shall establish a workgroup that includes affected agency representatives and stakeholders representing the institutional and home and community-based long term care interests. This Section shall not restrict the Department from implementing lower level of care eligibility criteria for community-based services in circumstances where federal approval has been granted.

Individuals with a score of 29 or higher based on the determination of need (DON) assessment tool shall be eligible to receive institutional and home and community-based long term care services until the State receives federal approval and implements an updated assessment tool, and those individuals are found to be ineligible under that updated assessment tool. Anyone determined to be ineligible for services due to the updated assessment tool shall continue to be eligible for services for at least one year following that determination and must be reassessed no earlier than 11 months after that determination. The Department must adopt rules through the regular rulemaking process regarding the updated assessment tool, and shall not adopt emergency or peremptory rules regarding the updated assessment tool. The State shall not implement an updated assessment tool that causes more than 1% of then-current recipients to lose eligibility. No individual receiving care in an institutional setting shall be involuntarily discharged as the result of the updated assessment tool until a transition plan has been developed by the Department on Aging or its designee and all care identified in the transition plan is available to the resident immediately upon discharge.

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

1 Section.

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

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

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

1 under this Section shall be limited to services associated with
2 kidney transplantation.
3 Notwithstanding any other provision of this Code to the
4 contrary, on or after July 1, 2015, all FDA approved forms of
5 medication assisted treatment prescribed for the treatment of
6 alcohol dependence or treatment of opioid dependence shall be
7 covered under both fee for service and managed care medical
8 assistance programs for persons who are otherwise eligible for
9 medical assistance under this Article and shall not be subject
10 to any (1) utilization control, other than those established
11 under the American Society of Addiction Medicine patient
12 placement criteria, (2) prior authorization mandate, or (3)
13 lifetime restriction limit mandate.
14 On or after July 1, 2015, opioid antagonists prescribed for
15 the treatment of an opioid overdose, including the medication
16 product, administration devices, and any pharmacy fees related
17 to the dispensing and administration of the opioid antagonist,
18 shall be covered under the medical assistance program for
19 persons who are otherwise eligible for medical assistance under
20 this Article. As used in this Section, "opioid antagonist"
21 means a drug that binds to opioid receptors and blocks or
22 inhibits the effect of opioids acting on those receptors,
23 including, but not limited to, naloxone hydrochloride or any
24 other similarly acting drug approved by the U.S. Food and Drug
25 Administration.
26 Upon federal approval, the Department shall provide

1 coverage and reimbursement for all drugs that are approved for
2 marketing by the federal Food and Drug Administration and that
3 are recommended by the federal Public Health Service or the
4 United States Centers for Disease Control and Prevention for
5 pre-exposure prophylaxis and related pre-exposure prophylaxis
6 services, including, but not limited to, HIV and sexually
7 transmitted infection screening, treatment for sexually
8 transmitted infections, medical monitoring, assorted labs, and
9 counseling to reduce the likelihood of HIV infection among
10 individuals who are not infected with HIV but who are at high
11 risk of HIV infection.
12 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
13 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
14 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
15 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
16 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section
17 20 of P.A. 99-588 for the effective date of P.A. 99-407);
18 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff.
19 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895,
20 eff. 1-1-17; revised 9-20-16.)

21 (305 ILCS 5/5-5.01a)
22 Sec. 5-5.01a. Supportive living facilities program. The
23 Department shall establish and provide oversight for a program
24 of supportive living facilities that seek to promote resident
25 independence, dignity, respect, and well-being in the most

1 cost-effective manner.
2 A supportive living facility is either a free-standing
3 facility or a distinct physical and operational entity within a
4 nursing facility. A supportive living facility integrates
5 housing with health, personal care, and supportive services and
6 is a designated setting that offers residents their own
7 separate, private, and distinct living units.
8 Sites for the operation of the program shall be selected by
9 the Department based upon criteria that may include the need
10 for services in a geographic area, the availability of funding,
11 and the site's ability to meet the standards.
12 Beginning July 1, 2014, subject to federal approval, the
13 Medicaid rates for supportive living facilities shall be equal
14 to the supportive living facility Medicaid rate effective on
15 June 30, 2014 increased by 8.85%. Once the assessment imposed
16 at Article V-G of this Code is determined to be a permissible
17 tax under Title XIX of the Social Security Act, the Department
18 shall increase the Medicaid rates for supportive living
19 facilities effective on July 1, 2014 by 9.09%. The Department
20 shall apply this increase retroactively to coincide with the
21 imposition of the assessment in Article V-G of this Code in
22 accordance with the approval for federal financial
23 participation by the Centers for Medicare and Medicaid
24 Services.
25 The Department may adopt rules to implement this Section.
26 Rules that establish or modify the services, standards, and

1 conditions for participation in the program shall be adopted by
2 the Department in consultation with the Department on Aging,
3 the Department of Rehabilitation Services, and the Department
4 of Mental Health and Developmental Disabilities (or their
5 successor agencies).
6 Facilities or distinct parts of facilities which are
7 selected as supportive living facilities and are in good
8 standing with the Department's rules are exempt from the
9 provisions of the Nursing Home Care Act and the Illinois Health
10 Facilities Planning Act.
11 Individuals with a score of 29 or higher based on the
12 determination of need (DON) assessment tool shall be eligible
13 to receive institutional and home and community-based long term
14 care services until the State receives federal approval and
15 implements an updated assessment tool, and those individuals
16 are found to be ineligible under that updated assessment tool.
17 Anyone determined to be ineligible for services due to the
18 updated assessment tool shall continue to be eligible for
19 services for at least one year following that determination and
20 must be reassessed no earlier than 11 months after that
21 determination. The Department must adopt rules through the
22 regular rulemaking process regarding the updated assessment
23 tool, and shall not adopt emergency or peremptory rules
24 regarding the updated assessment tool. The State shall not
25 implement an updated assessment tool that causes more than 1%
26 of then-current recipients to lose eligibility. No individual

1 receiving care in an institutional setting shall be
2 involuntarily discharged as the result of the updated
3 assessment tool until a transition plan has been developed by
4 the Department on Aging or its designee and all care identified
5 in the transition plan is available to the resident immediately
6 upon discharge.
7 (Source: P.A. 98-651, eff. 6-16-14.)

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