SB1784

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

SB1784

Introduced 2/9/2011, by Sen. Mattie Hunter

SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Administrative Procedure Act, the State Finance Act, the Nursing Home Care Act, and the Illinois Public Aid Code. Renames the Family Care Fund the Medical Interagency Program Fund. Provides that 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 (instead of a waiver under the Social Security Act resulting from a specified Family Care waiver request) and (ii) an interagency agreement. Makes changes to provisions concerning: the prescreening of long term care facility residents who apply for Medicaid; the FamilyCare program; emergency services audits; and other matters. Repeals a provision requiring the Department of Healthcare and Family Services to operate a pilot project to determine the effect of raising the income and non-exempt asset eligibility thresholds for certain persons with disabilities on those persons' ability to maintain their homes in the community and avoid institutionalization. Repeals a provision requiring the Department of Human Services and the Department of Healthcare and Family Services to jointly establish an interagency committee to assist the departments in making recommendations on incorporating health care advocates into education, training, and placement programs geared towards TANF recipients. Repeals The Illinois Welfare and Rehabilitation Services Planning Act. Effective immediately.

LRB097 06803 KTG 50212 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

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

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

6 (5 ILCS 100/5-70) (from Ch. 127, par. 1005-70)
7 Sec. 5-70. Form and publication of notices.
8 (a) The Secretary of State may prescribe reasonable rules
9 concerning the form of documents to be filed with the Secretary
10 of State and may refuse to accept for filing certified copies
11 that do not comply with the rules. In addition, the Secretary
12 of State shall publish and maintain the Illinois Register and
13 may prescribe reasonable rules setting forth the manner in
14 which agencies shall submit notices required by this Act for
15 publication in the Illinois Register. The Illinois Register
16 shall be published at least once each week on the same day
17 (unless that day is an official State holiday, in which case
18 the Illinois Register shall be published on the next following
19 business day) and sent to subscribers who subscribe for the
20 publication with the Secretary of State. The Secretary of State
21 may charge a subscription price to subscribers that covers
22 mailing and publication costs.
23 (b) The Secretary of State shall accept for publication in

1 the Illinois Register all Pollution Control Board documents,
2 including but not limited to Board opinions, the results of
3 Board determinations concerning adjusted standards
4 proceedings, notices of petitions for individual adjusted
5 standards, results of Board determinations concerning the
6 necessity for economic impact studies, restricted status
7 lists, hearing notices, and any other documents related to the
8 activities of the Pollution Control Board that the Board deems
9 appropriate for publication.
10 (c) The Secretary of State shall accept for publication in
11 the Illinois Register notices initiated by the Department of
12 Healthcare and Family Services in its capacity as the designate
13 Title XIX single State agency pursuant to the requirements
14 found at 42 CFR 447.205, and any other documents related to the
15 activities of the programs administered by the Department of
16 Healthcare and Family Services that the Department deems
17 appropriate for publication.
18 (Source: P.A. 87-823.)

19 (20 ILCS 10/Act rep.)
20 Section 4. The Illinois Welfare and Rehabilitation
21 Services Planning Act is repealed.

22 Section 6. The State Finance Act is amended by changing
23 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

1 source, including interest thereon.
2 (c) Subject to appropriation, the moneys in the Fund shall
3 be disbursed for reimbursement of medical services and other
4 costs associated with persons receiving such services:
5 (1) under programs administered by the Department of
6 Healthcare and Family Services (formerly Department of
7 Public Aid); and
8 (2) pursuant to an interagency agreement, under
9 programs administered by another agency of State
10 government.
11 (Source: P.A. 95-331, eff. 8-21-07.)

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

14 (210 ILCS 45/2-201.5)
15 Sec. 2-201.5. Screening prior to admission.
16 (a) All persons age 18 or older seeking admission to a
17 nursing facility must be screened to determine the need for
18 nursing facility services prior to being admitted, regardless
19 of income, assets, or funding source. ~~In addition, any person~~
20 ~~who seeks to become eligible for medical assistance from the~~
21 ~~Medical Assistance Program under the Illinois Public Aid Code~~
22 ~~to pay for long term care services while residing in a facility~~
23 ~~must be screened prior to receiving those benefits.~~ Screening
24 for nursing facility services shall be administered through

1 procedures established by administrative rule. Screening may
2 be done by agencies other than the Department as established by
3 administrative rule. This Section applies on and after July 1,
4 1996. No later than October 1, 2010, the Department of
5 Healthcare and Family Services, in collaboration with the
6 Department on Aging, the Department of Human Services, and the
7 Department of Public Health, shall file administrative rules
8 providing for the gathering, during the screening process, of
9 information relevant to determining each person's potential
10 for placing other residents, employees, and visitors at risk of
11 harm.
12 (a-1) Any screening performed pursuant to subsection (a) of
13 this Section shall include a determination of whether any
14 person is being considered for admission to a nursing facility
15 due to a need for mental health services. For a person who
16 needs mental health services, the screening shall also include
17 an evaluation of whether there is permanent supportive housing,
18 or an array of community mental health services, including but
19 not limited to supported housing, assertive community
20 treatment, and peer support services, that would enable the
21 person to live in the community. The person shall be told about
22 the existence of any such services that would enable the person
23 to live safely and humanely and about available appropriate
24 nursing home services that would enable the person to live
25 safely and humanely, and the person shall be given the
26 assistance necessary to avail himself or herself of any

1 available services.
2 (a-2) Pre-screening for persons with a serious mental
3 illness shall be performed by a psychiatrist, a psychologist, a
4 registered nurse certified in psychiatric nursing, a licensed
5 clinical professional counselor, or a licensed clinical social
6 worker, who is competent to (i) perform a clinical assessment
7 of the individual, (ii) certify a diagnosis, (iii) make a
8 determination about the individual's current need for
9 treatment, including substance abuse treatment, and recommend
10 specific treatment, and (iv) determine whether a facility or a
11 community-based program is able to meet the needs of the
12 individual.
13 For any person entering a nursing facility, the
14 pre-screening agent shall make specific recommendations about
15 what care and services the individual needs to receive,
16 beginning at admission, to attain or maintain the individual's
17 highest level of independent functioning and to live in the
18 most integrated setting appropriate for his or her physical and
19 personal care and developmental and mental health needs. These
20 recommendations shall be revised as appropriate by the
21 pre-screening or re-screening agent based on the results of
22 resident review and in response to changes in the resident's
23 wishes, needs, and interest in transition.
24 Upon the person entering the nursing facility, the
25 Department of Human Services or its designee shall assist the
26 person in establishing a relationship with a community mental

1 health agency or other appropriate agencies in order to (i)
2 promote the person's transition to independent living and (ii)
3 support the person's progress in meeting individual goals.
4 (a-3) The Department of Human Services, by rule, shall
5 provide for a prohibition on conflicts of interest for
6 pre-admission screeners. The rule shall provide for waiver of
7 those conflicts by the Department of Human Services if the
8 Department of Human Services determines that a scarcity of
9 qualified pre-admission screeners exists in a given community
10 and that, absent a waiver of conflicts, an insufficient number
11 of pre-admission screeners would be available. If a conflict is
12 waived, the pre-admission screener shall disclose the conflict
13 of interest to the screened individual in the manner provided
14 for by rule of the Department of Human Services. For the
15 purposes of this subsection, a "conflict of interest" includes,
16 but is not limited to, the existence of a professional or
17 financial relationship between (i) a PAS-MH corporate or a
18 PAS-MH agent and (ii) a community provider or long-term care
19 facility.
20 (b) In addition to the screening required by subsection
21 (a), a facility, except for those licensed as long term care
22 for under age 22 facilities, shall, within 24 hours after
23 admission, request a criminal history background check
24 pursuant to the Uniform Conviction Information Act for all
25 persons age 18 or older seeking admission to the facility,
26 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

1 Health, that the resident is an identified offender.
2 (2) Within 72 hours, arrange for a fingerprint-based
3 criminal history record inquiry to be requested on the
4 identified offender resident. The inquiry shall be based on
5 the subject's name, sex, race, date of birth, fingerprint
6 images, and other identifiers required by the Department of
7 State Police. The inquiry shall be processed through the
8 files of the Department of State Police and the Federal
9 Bureau of Investigation to locate any criminal history
10 record information that may exist regarding the subject.
11 The Federal Bureau of Investigation shall furnish to the
12 Department of State Police, pursuant to an inquiry under
13 this paragraph (2), any criminal history record
14 information contained in its files.
15 The facility shall comply with all applicable provisions
16 contained in the Uniform Conviction Information Act.
17 All name-based and fingerprint-based criminal history
18 record inquiries shall be submitted to the Department of State
19 Police electronically in the form and manner prescribed by the
20 Department of State Police. The Department of State Police may
21 charge the facility a fee for processing name-based and
22 fingerprint-based criminal history record inquiries. The fee
23 shall be deposited into the State Police Services Fund. The fee
24 shall not exceed the actual cost of processing the inquiry.
25 (d) (Blank).
26 (e) The Department shall develop and maintain a

1 de-identified database of residents who have injured facility
2 staff, facility visitors, or other residents, and the attendant
3 circumstances, solely for the purposes of evaluating and
4 improving resident pre-screening and assessment procedures
5 (including the Criminal History Report prepared under Section
6 2-201.6) and the adequacy of Department requirements
7 concerning the provision of care and services to residents. A
8 resident shall not be listed in the database until a Department
9 survey confirms the accuracy of the listing. The names of
10 persons listed in the database and information that would allow
11 them to be individually identified shall not be made public.
12 Neither the Department nor any other agency of State government
13 may use information in the database to take any action against
14 any individual, licensee, or other entity, unless the
15 Department or agency receives the information independent of
16 this subsection (e). All information collected, maintained, or
17 developed under the authority of this subsection (e) for the
18 purposes of the database maintained under this subsection (e)
19 shall be treated in the same manner as information that is
20 subject to Part 21 of Article VIII of the Code of Civil
21 Procedure.
22 (Source: P.A. 96-1372, eff. 7-29-10.)

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

1 (305 ILCS 5/5-2) (from Ch. 23, par. 5-2)
2 Sec. 5-2. Classes of Persons Eligible. Medical assistance
3 under this Article shall be available to any of the following
4 classes of persons in respect to whom a plan for coverage has
5 been submitted to the Governor by the Illinois Department and
6 approved by him:
7 1. Recipients of basic maintenance grants under
8 Articles III and IV.
9 2. Persons otherwise eligible for basic maintenance
10 under Articles III and IV, excluding any eligibility
11 requirements that are inconsistent with any federal law or
12 federal regulation, as interpreted by the U.S. Department
13 of Health and Human Services, but who fail to qualify
14 thereunder on the basis of need or who qualify but are not
15 receiving basic maintenance under Article IV, and who have
16 insufficient income and resources to meet the costs of
17 necessary medical care, including but not limited to the
18 following:
19 (a) All persons otherwise eligible for basic
20 maintenance under Article III but who fail to qualify
21 under that Article on the basis of need and who meet
22 either of the following requirements:
23 (i) their income, as determined by the
24 Illinois Department in accordance with any federal
25 requirements, is equal to or less than 70% in

1 fiscal year 2001, equal to or less than 85% in
2 fiscal year 2002 and until a date to be determined
3 by the Department by rule, and equal to or less
4 than 100% beginning on the date determined by the
5 Department by rule, of the nonfarm income official
6 poverty line, as defined by the federal Office of
7 Management and Budget and revised annually in
8 accordance with Section 673(2) of the Omnibus
9 Budget Reconciliation Act of 1981, applicable to
10 families of the same size; or
11 (ii) their income, after the deduction of
12 costs incurred for medical care and for other types
13 of remedial care, is equal to or less than 70% in
14 fiscal year 2001, equal to or less than 85% in
15 fiscal year 2002 and until a date to be determined
16 by the Department by rule, and equal to or less
17 than 100% beginning on the date determined by the
18 Department by rule, of the nonfarm income official
19 poverty line, as defined in item (i) of this
20 subparagraph (a).
21 (b) All persons who, excluding any eligibility
22 requirements that are inconsistent with any federal
23 law or federal regulation, as interpreted by the U.S.
24 Department of Health and Human Services, would be
25 determined eligible for such basic maintenance under
26 Article IV by disregarding the maximum earned income

1 permitted by federal law.

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

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

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

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

1 same size, provided that costs incurred for medical care
2 are not taken into account in determining such income
3 eligibility.
4 (c) The Illinois Department may conduct a
5 demonstration in at least one county that will provide
6 medical assistance to pregnant women, together with their
7 infants and children up to one year of age, where the
8 income eligibility standard is set up to 185% of the
9 nonfarm income official poverty line, as defined by the
10 federal Office of Management and Budget. The Illinois
11 Department shall seek and obtain necessary authorization
12 provided under federal law to implement such a
13 demonstration. Such demonstration may establish resource
14 standards that are not more restrictive than those
15 established under Article IV of this Code.
16 6. Persons under the age of 18 who fail to qualify as
17 dependent under Article IV and who have insufficient income
18 and resources to meet the costs of necessary medical care
19 to the maximum extent permitted under Title XIX of the
20 Federal Social Security Act.
21 7. Persons who are under 21 years of age and would
22 qualify as disabled as defined under the Federal
23 Supplemental Security Income Program, provided medical
24 service for such persons would be eligible for Federal
25 Financial Participation, and provided the Illinois
26 Department determines that:

1 (a) the person requires a level of care provided by
2 a hospital, skilled nursing facility, or intermediate
3 care facility, as determined by a physician licensed to
4 practice medicine in all its branches;
5 (b) it is appropriate to provide such care outside
6 of an institution, as determined by a physician
7 licensed to practice medicine in all its branches;
8 (c) the estimated amount which would be expended
9 for care outside the institution is not greater than
10 the estimated amount which would be expended in an
11 institution.
12 8. Persons who become ineligible for basic maintenance
13 assistance under Article IV of this Code in programs
14 administered by the Illinois Department due to employment
15 earnings and persons in assistance units comprised of
16 adults and children who become ineligible for basic
17 maintenance assistance under Article VI of this Code due to
18 employment earnings. The plan for coverage for this class
19 of persons shall:
20 (a) extend the medical assistance coverage for up
21 to 12 months following termination of basic
22 maintenance assistance; and
23 (b) offer persons who have initially received 6
24 months of the coverage provided in paragraph (a) above,
25 the option of receiving an additional 6 months of
26 coverage, subject to the following:

1 (i) such coverage shall be pursuant to
2 provisions of the federal Social Security Act;
3 (ii) such coverage shall include all services
4 covered while the person was eligible for basic
5 maintenance assistance;
6 (iii) no premium shall be charged for such
7 coverage; and
8 (iv) such coverage shall be suspended in the
9 event of a person's failure without good cause to
10 file in a timely fashion reports required for this
11 coverage under the Social Security Act and
12 coverage shall be reinstated upon the filing of
13 such reports if the person remains otherwise
14 eligible.
15 9. Persons with acquired immunodeficiency syndrome
16 (AIDS) or with AIDS-related conditions with respect to whom
17 there has been a determination that but for home or
18 community-based services such individuals would require
19 the level of care provided in an inpatient hospital,
20 skilled nursing facility or intermediate care facility the
21 cost of which is reimbursed under this Article. Assistance
22 shall be provided to such persons to the maximum extent
23 permitted under Title XIX of the Federal Social Security
24 Act.
25 10. Participants in the long-term care insurance
26 partnership program established under the Illinois

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

4 11. Persons with disabilities who are employed and
5 eligible for Medicaid, pursuant to Section
6 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and,
7 subject to federal approval, persons with a medically
8 improved disability who are employed and eligible for
9 Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of
10 the Social Security Act, as provided by the Illinois
11 Department by rule. In establishing eligibility standards
12 under this paragraph 11, the Department shall, subject to
13 federal approval:

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

16 (b) exempt retirement accounts that the person
17 cannot access without penalty before the age of 59 1/2,
18 and medical savings accounts established pursuant to
19 26 U.S.C. 220;

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

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

1 12. Subject to federal approval, persons who are
2 eligible for medical assistance coverage under applicable
3 provisions of the federal Social Security Act and the
4 federal Breast and Cervical Cancer Prevention and
5 Treatment Act of 2000. Those eligible persons are defined
6 to include, but not be limited to, the following persons:
7 (1) persons who have been screened for breast or
8 cervical cancer under the U.S. Centers for Disease
9 Control and Prevention Breast and Cervical Cancer
10 Program established under Title XV of the federal
11 Public Health Services Act in accordance with the
12 requirements of Section 1504 of that Act as
13 administered by the Illinois Department of Public
14 Health; and
15 (2) persons whose screenings under the above
16 program were funded in whole or in part by funds
17 appropriated to the Illinois Department of Public
18 Health for breast or cervical cancer screening.
19 "Medical assistance" under this paragraph 12 shall be
20 identical to the benefits provided under the State's
21 approved plan under Title XIX of the Social Security Act.
22 The Department must request federal approval of the
23 coverage under this paragraph 12 within 30 days after the
24 effective date of this amendatory Act of the 92nd General
25 Assembly.
26 In addition to the persons who are eligible for medical

1 assistance pursuant to subparagraphs (1) and (2) of this
2 paragraph 12, and to be paid from funds appropriated to the
3 Department for its medical programs, any uninsured person
4 as defined by the Department in rules residing in Illinois
5 who is younger than 65 years of age, who has been screened
6 for breast and cervical cancer in accordance with standards
7 and procedures adopted by the Department of Public Health
8 for screening, and who is referred to the Department by the
9 Department of Public Health as being in need of treatment
10 for breast or cervical cancer is eligible for medical
11 assistance benefits that are consistent with the benefits
12 provided to those persons described in subparagraphs (1)
13 and (2). Medical assistance coverage for the persons who
14 are eligible under the preceding sentence is not dependent
15 on federal approval, but federal moneys may be used to pay
16 for services provided under that coverage upon federal
17 approval.
18 13. Subject to appropriation and to federal approval,
19 persons living with HIV/AIDS who are not otherwise eligible
20 under this Article and who qualify for services covered
21 under Section 5-5.04 as provided by the Illinois Department
22 by rule.
23 14. Subject to the availability of funds for this
24 purpose, the Department may provide coverage under this
25 Article to persons who reside in Illinois who are not
26 eligible under any of the preceding paragraphs and who meet

1 the income guidelines of paragraph 2(a) of this Section and
2 (i) have an application for asylum pending before the
3 federal Department of Homeland Security or on appeal before
4 a court of competent jurisdiction and are represented
5 either by counsel or by an advocate accredited by the
6 federal Department of Homeland Security and employed by a
7 not-for-profit organization in regard to that application
8 or appeal, or (ii) are receiving services through a
9 federally funded torture treatment center. Medical
10 coverage under this paragraph 14 may be provided for up to
11 24 continuous months from the initial eligibility date so
12 long as an individual continues to satisfy the criteria of
13 this paragraph 14. If an individual has an appeal pending
14 regarding an application for asylum before the Department
15 of Homeland Security, eligibility under this paragraph 14
16 may be extended until a final decision is rendered on the
17 appeal. The Department may adopt rules governing the
18 implementation of this paragraph 14.
19 15. Family Care Eligibility.
20 (a) A caretaker relative who is 19 years of age or
21 older when countable income is at or below 185% of the
22 Federal Poverty Level Guidelines, as published
23 annually in the Federal Register, for the appropriate
24 family size. A person may not spend down to become
25 eligible under this paragraph 15.
26 (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 <u>60</u> ~~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

1 evaluation or treatment, or both diagnostic evaluation and
2 treatment, for prostate or testicular cancer. For the
3 purposes of this paragraph 16, uninsured persons are those
4 who do not have creditable coverage, as defined under the
5 Health Insurance Portability and Accountability Act, or
6 have otherwise exhausted any insurance benefits they may
7 have had, for prostate or testicular cancer diagnostic
8 evaluation or treatment, or both diagnostic evaluation and
9 treatment. To be eligible, a person must furnish a Social
10 Security number. A person's assets are exempt from
11 consideration in determining eligibility under this
12 paragraph 16. Such persons shall be eligible for medical
13 assistance under this paragraph 16 for so long as they need
14 treatment for the cancer. A person shall be considered to
15 need treatment if, in the opinion of the person's treating
16 physician, the person requires therapy directed toward
17 cure or palliation of prostate or testicular cancer,
18 including recurrent metastatic cancer that is a known or
19 presumed complication of prostate or testicular cancer and
20 complications resulting from the treatment modalities
21 themselves. Persons who require only routine monitoring
22 services are not considered to need treatment. "Medical
23 assistance" under this paragraph 16 shall be identical to
24 the benefits provided under the State's approved plan under
25 Title XIX of the Social Security Act. Notwithstanding any
26 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

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

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

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

17 (Source: P.A. 95-546, eff. 8-29-07; 95-1055, eff. 4-10-09;
18 96-20, eff. 6-30-09; 96-181, eff. 8-10-09; 96-328, eff.
19 8-11-09; 96-567, eff. 1-1-10; 96-1000, eff. 7-2-10; 96-1123,
20 eff. 1-1-11; 96-1270, eff. 7-26-10; revised 9-16-10.)

21 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

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

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

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

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

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

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

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

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

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

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

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

16 The Illinois Department shall authorize the provision of,
17 and shall authorize payment for, screening by low-dose
18 mammography for the presence of occult breast cancer for women
19 35 years of age or older who are eligible for medical
20 assistance under this Article, as follows:

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

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

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

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

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

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

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

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

1 Department shall provide for bonus payments to mammography
2 facilities meeting the standards for screening and diagnosis.
3 The bonus payments shall be at least 15% higher than the
4 Medicare rates for mammography.
5 Subject to federal approval, the Department shall
6 establish a rate methodology for mammography at federally
7 qualified health centers and other encounter-rate clinics.
8 These clinics or centers may also collaborate with other
9 hospital-based mammography facilities.
10 The Department shall establish a methodology to remind
11 women who are age-appropriate for screening mammography, but
12 who have not received a mammogram within the previous 18
13 months, of the importance and benefit of screening mammography.
14 The Department shall establish a performance goal for
15 primary care providers with respect to their female patients
16 over age 40 receiving an annual mammogram. This performance
17 goal shall be used to provide additional reimbursement in the
18 form of a quality performance bonus to primary care providers
19 who meet that goal.
20 The Department shall devise a means of case-managing or
21 patient navigation for beneficiaries diagnosed with breast
22 cancer. This program shall initially operate as a pilot program
23 in areas of the State with the highest incidence of mortality
24 related to breast cancer. At least one pilot program site shall
25 be in the metropolitan Chicago area and at least one site shall
26 be outside the metropolitan Chicago area. An evaluation of the

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

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

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

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

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

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

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

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

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

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

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

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

1 (2) The Department may elect to consider and negotiate
2 financial incentives to encourage the development of
3 Partnerships and the efficient delivery of medical care.
4 (3) Persons receiving medical services through
5 Partnerships may receive medical and case management
6 services above the level usually offered through the
7 medical assistance program.
8 Medical providers shall be required to meet certain
9 qualifications to participate in Partnerships to ensure the
10 delivery of high quality medical services. These
11 qualifications shall be determined by rule of the Illinois
12 Department and may be higher than qualifications for
13 participation in the medical assistance program. Partnership
14 sponsors may prescribe reasonable additional qualifications
15 for participation by medical providers, only with the prior
16 written approval of the Illinois Department.
17 Nothing in this Section shall limit the free choice of
18 practitioners, hospitals, and other providers of medical
19 services by clients. In order to ensure patient freedom of
20 choice, the Illinois Department shall immediately promulgate
21 all rules and take all other necessary actions so that provided
22 services may be accessed from therapeutically certified
23 optometrists to the full extent of the Illinois Optometric
24 Practice Act of 1987 without discriminating between service
25 providers.
26 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

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

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

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

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

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

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

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 without medical
26 authorization; and (2) rental, lease, purchase or

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

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

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

24 The Illinois Department shall report annually to the
25 General Assembly, no later than the second Friday in April of
26 1979 and each year thereafter, in regard to:

1 (a) actual statistics and trends in utilization of
2 medical services by public aid recipients;
3 (b) actual statistics and trends in the provision of
4 the various medical services by medical vendors;
5 (c) current rate structures and proposed changes in
6 those rate structures for the various medical vendors; and
7 (d) efforts at utilization review and control by the
8 Illinois Department.
9 The period covered by each report shall be the 3 years
10 ending on the June 30 prior to the report. The report shall
11 include suggested legislation for consideration by the General
12 Assembly. The filing of one copy of the report with the
13 Speaker, one copy with the Minority Leader and one copy with
14 the Clerk of the House of Representatives, one copy with the
15 President, one copy with the Minority Leader and one copy with
16 the Secretary of the Senate, one copy with the Legislative
17 Research Unit, and such additional copies with the State
18 Government Report Distribution Center for the General Assembly
19 as is required under paragraph (t) of Section 7 of the State
20 Library Act shall be deemed sufficient to comply with this
21 Section.
22 Rulemaking authority to implement Public Act 95-1045, if
23 any, is conditioned on the rules being adopted in accordance
24 with all provisions of the Illinois Administrative Procedure
25 Act and all rules and procedures of the Joint Committee on
26 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

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

9 "DHS" means the Illinois Department of Human Services.

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

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

1 XIX of the Social Security Act.
2 "Long term care provider" means (i) a person licensed by
3 the Department of Public Health to operate and maintain a
4 skilled nursing or intermediate long term care facility or (ii)
5 a hospital provider that provides skilled or intermediate long
6 term care services within the meaning of Title XVIII or XIX of
7 the Social Security Act. For purposes of this definition,
8 "person" means any political subdivision of the State,
9 municipal corporation, individual, firm, partnership,
10 corporation, company, limited liability company, association,
11 joint stock association, or trust, or a receiver, executor,
12 trustee, guardian, or other representative appointed by order
13 of any court.
14 "State-operated developmentally disabled care facility"
15 means an intermediate care facility for the mentally retarded
16 within the meaning of Title XIX of the Social Security Act
17 operated by the State.
18 (c) Administration and deposit of Revenues. The Department
19 shall coordinate the implementation of changes required by this
20 amendatory Act of the 96th General Assembly amongst the various
21 State and local government bodies that administer programs
22 referred to in this Section.
23 Revenues generated by program changes mandated by any
24 provision in this Section, less reasonable administrative
25 costs associated with the implementation of these program
26 changes, which would otherwise be deposited into the General

1 Revenue Fund shall be deposited into the Healthcare Provider
2 Relief Fund.
3 The Department shall issue a report to the General Assembly
4 detailing the implementation progress of this amendatory Act of
5 the 96th General Assembly as a part of the Department's Medical
6 Programs annual report for fiscal years 2010 and 2011.
7 (d) Acceleration of payment vouchers. To the extent
8 practicable and permissible under federal law, the Department
9 shall create all vouchers for long term care facilities and
10 developmentally disabled care facilities for dates of service
11 in the month in which the enhanced federal medical assistance
12 percentage (FMAP) originally set forth in the American Recovery
13 and Reinvestment Act (ARRA) expires and for dates of service in
14 the month prior to that month and shall, no later than the 15th
15 of the month in which the enhanced FMAP expires, submit these
16 vouchers to the Comptroller for payment.
17 The Department of Human Services shall create the necessary
18 documentation for State-operated developmentally disabled care
19 facilities so that the necessary data for all dates of service
20 before the expiration of the enhanced FMAP originally set forth
21 in the ARRA can be adjudicated by the Department no later than
22 the 15th of the month in which the enhanced FMAP expires.
23 (e) Billing of DHS community Medicaid mental health
24 services. No later than July 1, 2011, community Medicaid mental
25 health services provided by a community-based provider must be
26 billed directly to the Department.

1 (f) DCFS Medicaid services. The Department shall work with
2 DCFS to identify existing programs, pending qualifying
3 services, that can be converted in an economically feasible
4 manner to Medicaid in order to secure federal financial
5 revenue.
6 (g) Third Party Liability recoveries. The Department shall
7 contract with a vendor to support the Department in
8 coordinating benefits for Medicaid enrollees. The scope of work
9 shall include, at a minimum, the identification of other
10 insurance for Medicaid enrollees and the recovery of funds paid
11 by the Department when another payer was liable. The vendor may
12 be paid a percentage of actual cash recovered when practical
13 and subject to federal law.
14 (h) Public health departments. The Department shall
15 identify unreimbursed costs for persons covered by Medicaid who
16 are served by the Chicago Department of Public Health.
17 The Department shall assist the Chicago Department of
18 Public Health in determining total unreimbursed costs
19 associated with the provision of healthcare services to
20 Medicaid enrollees.
21 The Department shall determine and draw the maximum
22 allowable federal matching dollars associated with the cost of
23 Chicago Department of Public Health services provided to
24 Medicaid enrollees.
25 (i) Acceleration of hospital-based payments. The
26 Department shall, by the 10th day of the month in which the

1 enhanced FMAP originally set forth in the ARRA expires, create
2 vouchers for all State fiscal year 2011 hospital payments
3 exempt from the prompt payment requirements of the ARRA. The
4 Department shall submit these vouchers to the Comptroller for
5 payment.
6 (Source: P.A. 96-1405, eff. 7-29-10; revised 9-9-10.)

7 (305 ILCS 5/12-10.5)
8 Sec. 12-10.5. Medical Special Purposes Trust Fund.
9 (a) The Medical Special Purposes Trust Fund ("the Fund") is
10 created. Any grant, gift, donation, or legacy of money or
11 securities that the Department of Healthcare and Family
12 Services is authorized to receive under Section 12-4.18 or
13 Section 12-4.19, and that is dedicated for functions connected
14 with the administration of any medical program administered by
15 the Department, shall be deposited into the Fund. All federal
16 moneys received by the Department as reimbursement for
17 disbursements authorized to be made from the Fund shall also be
18 deposited into the Fund. In addition, federal moneys received
19 on account of State expenditures made in connection with
20 obtaining compliance with the federal Health Insurance
21 Portability and Accountability Act (HIPAA) shall be deposited
22 into the Fund.
23 (b) No moneys received from a service provider or a
24 governmental or private entity that is enrolled with the
25 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.

1 INDEX

2 Statutes amended in order of appearance

3	5 ILCS 100/5-70	from Ch. 127, par. 1005-70
4	20 ILCS 10/Act rep.	
5	30 ILCS 105/5.573	
6	30 ILCS 105/6z-58	
7	210 ILCS 45/2-201.5	
8	305 ILCS 5/5-2	from Ch. 23, par. 5-2
9	305 ILCS 5/5-5	from Ch. 23, par. 5-5
10	305 ILCS 5/5-26	
11	305 ILCS 5/5A-9	from Ch. 23, par. 5A-9
12	305 ILCS 5/12-4.42	
13	305 ILCS 5/12-10.5	
14	305 ILCS 5/5-2.4 rep.	
15	305 ILCS 5/9A-9.5 rep.	