Sen. Antonio Muñoz

Filed: 4/28/2015

AMENDMENT TO SENATE BILL 1254

AMENDMENT NO. _____. Amend Senate Bill 1254 by replacing everything after the enacting clause with the following:

"Section 1. As used in this Section, "Affordable Care Act" is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

The Affordable Care Act has increased the number of individuals utilizing health care services and enrolling in the programs administered by the Department of Healthcare and Family Services. The needs of these individuals and the budgetary constraints of the State of Illinois dictate that payment for these services shall be consistent with efficiency, economy, and quality of care and based on principles that maintain access to care and avoid and reduce fraud. One manner by which these objectives shall be achieved is through the utilization of a uniform certification of medical necessity for

non-emergency ambulance transportation. This certification will help ensure that payment is based on the appropriate medical level of non-emergency transportation and, thus, will help establish medical necessity and prevent overutilization of services and unnecessary transportation. Another manner by which these objectives shall be achieved is through the transition from the Department's current payment methodology based on the county of the primary office location of the enrolled transportation provider to a payment methodology based on the zip code of an individual's point of pick-up by the transportation provider. Yet another manner by which these objectives shall be achieved is to limit the number of enrollment applications and agreements required by a transportation provider. Numerous enrollment applications and agreements for a transportation provider increases the risk of fraud and abuse by, among other things, enabling a provider to hide behind multiple agreements in order to continue provider enrollment and reimbursement.

Section 5. The Nursing Home Care Act is amended by changing Section 2-217 as follows:

(210 ILCS 45/2-217)

Sec. 2-217. Order for transportation of resident by ambulance.

(a) If a facility orders transportation of a resident of

the facility by ambulance, the facility must maintain a written record that shows (i) the name of the person who placed the order for that transportation and (ii) the medical reason for that transportation. The facility must maintain the record for a period of at least 3 years after the date of the order for transportation by ambulance.

(b) Beginning for dates of service no later than 90 days after the effective date of this amendatory Act of the 99th General Assembly, a facility shall utilize the uniform certification of medical necessity for non-emergency ambulance transportation pursuant to Section 5-4.2 of the Illinois Public Aid Code for all non-emergency ambulance transportation, regardless of whether the payer for the transport is a governmental payer or a non-governmental payer and regardless of the type of health care program or insurance the individual participates in. The uniform certification is not required prior to transport if it is reasonable to believe a delay in transport can be expected to negatively affect the efficient transportation of residents from the facility as determined by the facility.

(c) It is the intention of the General Assembly that the State action exemption to the application of federal and State antitrust statutes be fully available to the Department, its vendors, agents, designees, and facilities, and all employees, officers, subsidiaries, and designees thereof, to the extent the activities facilitate the efficient transportation of

residents and provide a streamlined uniform medical necessity certification process.

The State action exemption shall be liberally construed in favor of the Department, its vendors, agents, designees, and facilities, and all employees, officers, subsidiaries, and designees thereof, and such exemption shall be available notwithstanding that the action constitutes an irregular exercise of constitutional or statutory powers.

It is the policy of this State that the following powers may be exercised by the Department, its vendors, agents, designees, and facilities, and all employees, officers, subsidiaries, and designees thereof, notwithstanding the effects on competition and notwithstanding any displacement of competition:

(1) all powers that are within traditional areas of the Department's activity but that are authorized by this amendatory Act of the 99th General Assembly to be implemented by the Department's vendors, agents, designees, and facilities, and all employees, officers, subsidiaries, and designees thereof;

(2) all powers granted, either expressly or by necessary implication under this amendatory Act of the 99th General Assembly, or any administrative rules, policies, or procedures that implement this amendatory Act of the 99th General Assembly; or

(3) all powers that are the inherent, logical, or

ordinary results of the powers granted by this amendatory Act of the 99th General Assembly or any administrative rules, policies, or procedures that implement this amendatory Act of the 99th General Assembly.

In order to ensure that the non-Department individuals or entities identified in this subsection promote State policy and not individual interest, the Department shall actively supervise their activities, including, but not limited to, their decisions. The Department's active supervision shall include, but not be limited to, a review of the substance of any activities or decisions and the power to veto or modify particular activities or decisions to ensure they accord with State policy. The mere potential for State supervision shall not be a sufficient substitute for an actual decision by the Department. Department supervisors shall not be active market participants.

(Source: P.A. 94-1063, eff. 1-31-07.)

Section 10. The Hospital Licensing Act is amended by changing Section 6.22 as follows:

(210 ILCS 85/6.22)

Sec. 6.22. Arrangement for transportation of patient by ambulance.

(a) In this Section:

"Ambulance service provider" means a Vehicle Service

Provider as defined in the Emergency Medical Services (EMS) Systems Act who provides non-emergency transportation services by ambulance.

"Patient" means a person who is transported by an ambulance service provider.

(b) Beginning for dates of service no later than 90 days after the effective date of this amendatory act of the 99th General Assembly, a hospital shall utilize the uniform certification of medical necessity for non-emergency ambulance transportation pursuant to Section 5-4.2 of the Illinois Public Aid Code for all non-emergency ambulance transports, regardless of whether the payer for the transport is a governmental payer or a non-governmental payer and regardless of the type of health care program or insurance the patient participates in. The uniform certification is not required prior to transport if it is reasonable to believe a delay in transport can be expected to negatively affect the efficient flow of patients from the hospital as determined by the hospital. ~~If a hospital arranges for transportation of a patient of the hospital by ambulance, the hospital must provide the ambulance service provider, prior to transport, a Physician Certification Statement formatted and completed in compliance with federal regulations or an equivalent form developed by the hospital.~~

(b-5) It is the intention of the General Assembly that the State action exemption to the application of federal and State

antitrust statutes be fully available to the Department, its vendors, agents, designees, and hospitals, and all employees, officers, subsidiaries, and designees thereof, to the extent the activities facilitate the efficient transportation of patients and provide a streamlined uniform medical necessity certification process.

The State action exemption shall be liberally construed in favor of the Department, its vendors, agents, designees, and hospitals, and all employees, officers, subsidiaries, and designees thereof, and such exemption shall be available notwithstanding that the action constitutes an irregular exercise of constitutional or statutory powers.

It is the policy of this State that the following powers may be exercised by the Department, its vendors, agents, designees, and hospitals, and all employees, officers, subsidiaries, and designees thereof, notwithstanding the effects on competition and notwithstanding any displacement of competition:

(1) all powers that are within traditional areas of the Department's activity but that are authorized by this amendatory Act of the 99th General Assembly to be implemented by the Department's vendors, agents, designees, and hospitals, and all employees, officers, subsidiaries, and designees thereof;

(2) all powers granted, either expressly or by necessary implication by this amendatory Act of the 99th

General Assembly, or any administrative rules, policies, or procedures that implement this amendatory Act of the 99th General Assembly; or

(3) all powers that are the inherent, logical, or ordinary results of the powers granted by this amendatory Act of the 99th General Assembly or any administrative rules, policies, or procedures that implement this amendatory Act of the 99th General Assembly.

In order to ensure that the non-Department individuals or entities identified in this subsection promote State policy and not individual interest, the Department shall actively supervise the activities, including, but not limited to, the decisions, of the non-Department individual or entity that are authorized and made pursuant to this amendatory Act of the 99th General Assembly. The Department's active supervision shall include, but not be limited to, a review of the substance of any activities or decisions and the power to veto or modify particular activities or decisions to ensure they accord with State policy. The mere potential for State supervision shall not be a sufficient substitute for an actual decision by the Department. Department supervisors shall not be active market participants.

~~The Physician Certification Statement or equivalent form is not required prior to transport if a delay in transport can be expected to negatively affect the patient outcome.~~

(c) If a hospital is unable to provide a uniform

certification of medical necessity for non-emergency ambulance transportation ~~a Physician Certification Statement or equivalent form~~, then the hospital shall provide to the patient a written notice and a verbal explanation of the written notice, which notice must meet all of the following requirements:

(1) The following caption must appear at the beginning of the notice in at least 14-point type: Notice to Patient Regarding Non-Emergency Ambulance Services.

(2) The notice must contain each of the following statements in at least 14-point type:

(A) The purpose of this notice is to help you make an informed choice about whether you want to be transported by ambulance because your medical condition does not meet medical necessity for transportation by an ambulance.

(B) Your insurance may not cover the charges for ambulance transportation.

(C) You may be responsible for the cost of ambulance transportation.

(D) The estimated cost of ambulance transportation is $(amount).

(3) The notice must be signed by the patient or by the patient's authorized representative. A copy shall be given to the patient and the hospital shall retain a copy.

(d) The notice set forth in subsection (c) of this Section

shall not be required if a delay in transport can be expected to negatively affect the patient outcome.

(e) If a patient is physically or mentally unable to sign the notice described in subsection (c) of this Section and no authorized representative of the patient is available to sign the notice on the patient's behalf, the hospital must be able to provide documentation of the patient's inability to sign the notice and the unavailability of an authorized representative. In any case described in this subsection (e), the hospital shall be considered to have met the requirements of subsection (c) of this Section.

(Source: P.A. 94-1063, eff. 1-31-07.)

Section 15. The Illinois Public Aid Code is amended by changing Sections 5-4.2 and 5-5 as follows:

(305 ILCS 5/5-4.2) (from Ch. 23, par. 5-4.2)

Sec. 5-4.2. Ground ambulance ~~Ambulance~~ services, medi-car services, and service car services payments.

(a) For purposes of this Section, the following terms have the following meanings:

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

"Ground ambulance services" means medical transportation services that are described as ground ambulance services by the federal Centers for Medicare and Medicaid Services in 42 CFR

414.605 and any subsequent amendments, policies, and guidelines thereto and that are provided in a vehicle that is (i) licensed as an ambulance by the Department of Public Health pursuant to the Emergency Medical Services (EMS) Systems Act or (ii) licensed as an ambulance in another state in accordance with the laws of that state.

"Ground ambulance services provider" means a vehicle service provider as described in the Emergency Medical Services (EMS) Systems Act that provides emergency ground ambulance services or non-emergency ground ambulance services, or both. "Ground ambulance services provider" includes a vehicle service provider that is licensed in another state pursuant to the laws of that other state.

"Medi-car services provider" means a provider of medi-car services.

"Medi-car services" means medical transportation services provided by means of vehicles licensed by the Secretary of State as medi-car vehicles and, for organizations headquartered outside Illinois, by means of vehicles authorized to do business as medi-car vehicles pursuant to the laws of the state in which the organization is headquartered.

"Payment principles of Medicare" means the accepted methods propounded by the federal Centers for Medicare and Medicaid Services and used to determine the administration of the payment system for ground ambulance services providers and suppliers under Title XVIII of the Social Security Act. These

principles are outlined in the United States Code and the Code of Federal Regulations and in the procedures, policies, guidelines, and coding systems of the federal Centers for Medicare and Medicaid services, including, but not limited to, the CMS Online Manual System, the Medicare Benefit Policy Manual, the Medicare Claims Processing Manual, the Health Care Common Procedure Coding System (HCPCS), and the ambulance condition coding system.

"Service car services" means transportation services provided by means of a service car licensed as a livery car by the Secretary of State and, where applicable, by local regulatory agencies or, for organizations headquartered outside of Illinois, by means of vehicles authorized to do business as service cars pursuant to the laws of the state in which the organization is headquartered.

"Emergency and urgently needed services" has the meaning ascribed to that term in 42 CFR 422.113 and any subsequent amendments, policies, and guidelines thereto.

(b) Unless otherwise indicated in this Section, the practices of the Department concerning payments for ground ambulance services provided to recipients covered by a medical assistance program administered by the Department shall be consistent with the payment principles of Medicare.

(c) For ground ambulance services and medi-car services provided to recipients covered by a medical assistance program administered by the Department, payment shall be based upon the

zip code of the point of pick-up of the recipient by the ground ambulance services provider or medi-car services provider. The payment rate of each zip code shall equal the rate of the county in the Department-issued fee schedule where the zip code is located. For zip codes that exist in multiple counties, payment shall equal the rate in the Department-issued fee schedule of the county which includes the majority of the land area that the zip code covers. The payment methodology based on the zip code point of pick-up, as described in this subsection, shall be established by rule and shall be effective no later than January 1, 2016 in order to give the Department sufficient time to transition from its current payment methodology which is based upon the county of the primary office address listed in the transportation provider's enrollment application.

(c-5) Due to the unique mobile nature of ambulance and medi-car services, ground ambulance services providers and medi-car services providers are required to only submit enrollment applications for the primary office location where the provider's business is headquartered. Nothing in this Section shall be construed or applied either retroactively or prospectively to require ground ambulance services providers and medi-car services providers to have more than one enrollment application and Medicaid provider number. The Department shall implement this subsection by rule.

(d) Payment for mileage shall be per loaded mile with no loaded mileage included in the base rate. If a natural

disaster, weather, road repairs, traffic congestion, or other conditions necessitate a route other than the most direct route, payment shall be based upon the actual distance traveled. When a ground ambulance services provider provides transport, no reduction in the mileage payment shall be made based upon the fact that a closer facility may have been available, so long as the ground ambulance services provider provided transport to the recipient's facility of choice or another appropriate facility described within the scope of the Emergency Medical Services (EMS) Systems Act or associated rules or the policies and procedures of the EMS System of which the provider is a member or, in the case of a ground ambulance services provider licensed by another state, according to the laws, rules, policies, or procedures of the state in which the provider is licensed.

(d-5) The Department shall provide payment for emergency and urgently needed ground ambulance services according to the requirements provided in this Section when those services are emergency and urgently needed services. Such services may, but shall not be required to, be provided pursuant to a request made through a 9-1-1 or equivalent emergency telephone number for evaluation, treatment, and transport of or on behalf of an individual with a condition of such a nature that a prudent layperson would have reasonably expected that a delay in seeking immediate medical attention would have been hazardous to life or health. This standard is deemed to be met if there

is an emergency or urgent medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine can reasonably expect that the absence of immediate medical attention could result in placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

~~(a) For ambulance services provided to a recipient of aid under this Article on or after January 1, 1993, the Illinois Department shall reimburse ambulance service providers at rates calculated in accordance with this Section. It is the intent of the General Assembly to provide adequate reimbursement for ambulance services so as to ensure adequate access to services for recipients of aid under this Article and to provide appropriate incentives to ambulance service providers to provide services in an efficient and cost-effective manner. Thus, it is the intent of the General Assembly that the Illinois Department implement a reimbursement system for ambulance services that, to the extent practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, is consistent with the payment principles of Medicare. To ensure uniformity between the payment principles of Medicare and~~

~~Medicaid, the Illinois Department shall follow, to the extent necessary and practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, the statutes, laws, regulations, policies, procedures, principles, definitions, guidelines, and manuals used to determine the amounts paid to ambulance service providers under Title XVIII of the Social Security Act (Medicare).~~

~~(b) For ambulance services provided to a recipient of aid under this Article on or after January 1, 1996, the Illinois Department shall reimburse ambulance service providers based upon the actual distance traveled if a natural disaster, weather conditions, road repairs, or traffic congestion necessitates the use of a route other than the most direct route.~~

~~(c) For purposes of this Section, "ambulance services" includes medical transportation services provided by means of an ambulance, medi car, service car, or taxi.~~

~~(c 1) For purposes of this Section, "ground ambulance service" means medical transportation services that are described as ground ambulance services by the Centers for Medicare and Medicaid Services and provided in a vehicle that is licensed as an ambulance by the Illinois Department of Public Health pursuant to the Emergency Medical Services (EMS) Systems Act.~~

~~(c 2) For purposes of this Section, "ground ambulance service provider" means a vehicle service provider as described~~

~~in the Emergency Medical Services (EMS) Systems Act that operates licensed ambulances for the purpose of providing emergency ambulance services, or non-emergency ambulance services, or both. For purposes of this Section, this includes both ambulance providers and ambulance suppliers as described by the Centers for Medicare and Medicaid Services.~~

~~(d) This Section does not prohibit separate billing by ambulance service providers for oxygen furnished while providing advanced life support services.~~

(e) Beginning with services rendered on or after July 1, 2008, all providers of non-emergency medi-car and service car transportation must certify that the driver and employee attendant, as applicable, have completed a safety program approved by the Department to protect both the patient and the driver, prior to transporting a patient. The provider must maintain this certification in its records. The provider shall produce such documentation upon demand by the Department or its representative. Failure to produce documentation of such training shall result in recovery of any payments made by the Department for services rendered by a non-certified driver or employee attendant. Medi-car and service car providers must maintain legible documentation in their records of the driver and, as applicable, employee attendant that actually transported the patient. Providers must recertify all drivers and employee attendants every 3 years.

Notwithstanding the requirements above, any public

transportation provider of medi-car and service car transportation that receives federal funding under 49 U.S.C. 5307 and 5311 need not certify its drivers and employee attendants under this Section, since safety training is already federally mandated.

(f) With respect to any policy or program administered by the Department or its agent regarding approval of non-emergency medical transportation by ground ambulance services ~~service~~ providers and, beginning for dates of service no later than 90 days after the effective date of this amendatory Act of the 99th General Assembly, by medi-car services providers, including, but not limited to, the Non-Emergency Transportation Services Prior Approval Program (NETSPAP), the Department shall establish by rule a process by which ground ambulance services ~~service~~ providers and medi-car services providers of non-emergency medical transportation may appeal any decision by the Department or its agent for which no denial was received prior to the time of transport that either (i) denies a request for approval for payment of non-emergency transportation by means of ground ambulance services or medi-car services ~~service~~ or (ii) grants a request for approval of non-emergency transportation by means of ground ambulance services or medi-car services ~~service~~ at a level of service that entitles the ground ambulance services ~~service~~ provider or medi-car services provider to a lower level of compensation from the Department than the ground ambulance services ~~service~~

provider or medi-car services provider would have received as compensation for the level of service requested. The rule shall ~~be filed by December 15, 2012 and shall~~ provide that~~, for any decision rendered by the Department or its agent on or after the date the rule takes effect,~~ the ground ambulance services ~~service~~ provider and medi-car services provider shall have 60 days from the date the decision is received to file an appeal. The rule established by the Department shall be~~, insofar as is practical,~~ consistent with the Illinois Administrative Procedure Act. The decision of the Director ~~Director's decision~~ on an appeal under this Section shall be a final administrative decision subject to review under the Administrative Review Law.

(f-5) Beginning 90 days after July 20, 2012 (the effective date of Public Act 97-842) and, for medi-car services, beginning 90 days after the effective date of this amendatory Act of the 99th General Assembly, (i) no denial of a request for approval for payment of non-emergency transportation by means of ground ambulance services ~~service~~ or medi-car services, and (ii) no approval of non-emergency transportation by means of ground ambulance services or medi-car services ~~service~~ at a level of service that entitles the ground ambulance service provider to a lower level of compensation from the Department than would have been received at the level of service submitted by the ground ambulance services ~~service~~ provider or medi-car services provider, may be issued by the Department or its agent unless the Department has submitted the

criteria for determining the appropriateness of the transport for first notice publication in the Illinois Register pursuant to Section 5-40 of the Illinois Administrative Procedure Act.

(g) (Blank). ~~Whenever a patient covered by a medical assistance program under this Code or by another medical program administered by the Department is being discharged from a facility, a physician discharge order as described in this Section shall be required for each patient whose discharge requires medically supervised ground ambulance services. Facilities shall develop procedures for a physician with medical staff privileges to provide a written and signed physician discharge order. The physician discharge order shall specify the level of ground ambulance services needed and complete a medical certification establishing the criteria for approval of non emergency ambulance transportation, as published by the Department of Healthcare and Family Services, that is met by the patient. This order and the medical certification shall be completed prior to ordering an ambulance service and prior to patient discharge.~~

~~Pursuant to subsection (E) of Section 12-4.25 of this Code, the Department is entitled to recover overpayments paid to a provider or vendor, including, but not limited to, from the discharging physician, the discharging facility, and the ground ambulance service provider, in instances where a non emergency ground ambulance service is rendered as the result of improper or false certification.~~

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

(h-5) Beginning for dates of service no later than 90 days after the effective date of this amendatory Act of the 99th General Assembly, whenever a recipient covered by a medical assistance program administered by the Department or by the federal Medicare program is being transported on a non-emergency basis from a hospital, as described in the Hospital Licensing Act or the University of Illinois Hospital Act, or from a nursing facility, as described in the Nursing Home Care Act, a uniform certification of medical necessity for non-emergency ambulance transportation, as described in this subsection, shall be required for each recipient whose transportation requires medically supervised ground ambulance services. Facilities shall develop procedures for a physician with medical staff privileges or appropriate designee to provide a written and signed uniform certification of medical necessity for non-emergency ambulance transportation. The uniform certification of medical necessity for non-emergency ambulance transportation shall be established by rule and shall specify the level of ground ambulance services needed and shall establish the medical necessity for the transport in accordance with Medicare requirements set forth in 42 CFR 410.40 and any

subsequent amendments, policies, procedures, and guidelines thereto. Pursuant to subsection (E) of Section 12-4.25 of this Code, the Department is entitled to recover overpayments paid to a provider, including, but not limited to, from the physician, hospital, or nursing facility ordering the transportation, or the ground ambulance services provider providing the transportation, in instances where a non-emergency ground ambulance service is rendered as the result of an improper or false certification.

(h-6) It is the intention of the General Assembly that the State action exemption to the application of federal and State antitrust statutes be fully available to the Department, its vendors, agents, designees, and enrolled providers, and all employees, officers, subsidiaries, and designees thereof, to the extent the activities relate to the mileage criteria and methodology, emergency and urgently needed methodology and criteria, appeals process including post authorization for non-prescheduled, non-emergency transportation, and uniform certification of medical necessity for non-emergency ambulance transportation.

The State action exemption shall be liberally construed in favor of the Department, its vendors, agents, designees, and enrolled providers, and all employees, officers, subsidiaries, and designees thereof, and such exemption shall be available notwithstanding that the action constitutes an irregular exercise of constitutional or statutory powers.

It is the policy of this State that the following powers may be exercised by the Department, its vendors, agents, designees, and enrolled providers, and all employees, officers, subsidiaries, and designees thereof, notwithstanding the effects on competition and notwithstanding any displacement of competition:

(1) all powers that are within traditional areas of the Department's activity but that are to be implemented by the Department's vendors, agents, designees, and enrolled providers, and all employees, officers, subsidiaries, and designees thereof, pursuant to this amendatory Act of the 99th General Assembly only as the powers relate to mileage criteria and methodology, emergency and urgently needed methodology and criteria, appeals processes including post authorization for non-prescheduled, non-emergency transportation, and uniform certification of medical necessity for non-emergency ambulance transportation.

(2) all powers granted, either expressly or by necessary implication, by this amendatory act of the 99th General Assembly or any rules, policies, or procedures that implement this amendatory act of the 99th General Assembly only if such powers, rules, policies, or procedures relate to: mileage criteria and methodology, emergency and urgently needed methodology and criteria, appeals processes including post authorization for non-prescheduled, non-emergency transportation, and

uniform certification of medical necessity for non-emergency ambulance transportation; or

(3) all powers that are the inherent, logical, or ordinary results of the powers granted by this amendatory Act of the 99th General Assembly or any rules, policies, or procedures that implement this amendatory Act of the 99th General Assembly only if such powers, rules, policies, or procedures relate to: mileage criteria and methodology, emergency and urgently needed methodology and criteria, appeals processes including post authorization for non-prescheduled, non-emergency transportation, and uniform certification of medical necessity for non-emergency ambulance transportation.

In order to ensure that the non-Department individuals or entities identified in this subsection promote State policy and not individual interest, the Department shall actively supervise their activities and their decisions. The Department's active supervision shall include, but not be limited to, a review of the substance of any activities or decisions and the power to veto or modify particular activities or decisions to ensure they accord with State policy. The mere potential for State supervision shall not be a sufficient substitute for an actual decision by the Department. Department supervisors shall not be active market participants.

(i) Beginning no later than July 1, 2015, the Department shall establish a technical advisory group to collaborate with

and assist in the development of the regulations, policies, or procedures necessary to implement this amendatory Act of the 99th General Assembly. This technical advisory group shall include a statewide association representing municipal, not-for-profit and private providers as a diverse, statewide representation of the ambulance community, a statewide association representing emergency physicians, a statewide association representing hospitals, and a statewide association representing nursing facilities. The Department shall share information with and provide technical assistance to the non-Departmental members of the group. The Department shall share all drafts of administrative rules, policies, and procedures developed pursuant to this amendatory Act of the 99th General Assembly with the technical advisory group at least 90 days prior to the implementation date.

(Source: P.A. 97-584, eff. 8-26-11; 97-689, eff. 6-14-12; 97-842, eff. 7-20-12; 98-463, eff. 8-16-13.)

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home

services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, including to ensure that the individual's need for intervention or treatment of mental disorders or substance use disorders or co-occurring mental health and substance use disorders is determined using a uniform screening, assessment, and evaluation process inclusive of criteria, for children and adults; for purposes of this item (13), a uniform screening, assessment, and evaluation process refers to a process that includes an appropriate evaluation and, as warranted, a referral; "uniform" does not mean the use of a singular

instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary pursuant to 5-4.2 of this Code; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State, but not including abortions, or induced miscarriages or premature births, unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child. The Illinois Department, by rule, shall prohibit any physician from providing medical assistance to anyone eligible therefor under this Code where such physician has been found guilty of performing an abortion procedure in a wilful and wanton manner upon a woman who was not pregnant at the time such abortion procedure was performed. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

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

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.

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

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

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

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

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

(C) A mammogram at the age and intervals considered medically necessary by the woman's health care provider for women under 40 years of age and having a family history of

breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.

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

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

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

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

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

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

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

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. An evaluation of the pilot program shall be carried out measuring health outcomes and cost of care for those served by the pilot program compared to similarly situated patients who are not served by the pilot program.

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

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

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

the number of drug-affected infants born to recipients of medical assistance.

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

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

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

The sponsor must negotiate formal written contracts with medical providers for physician services, inpatient and outpatient hospital care, home health services, treatment for

alcoholism and substance abuse, and other services determined necessary by the Illinois Department by rule for delivery by Partnerships. Physician services must include prenatal and obstetrical care. The Illinois Department shall reimburse medical services delivered by Partnership providers to clients in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

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

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

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

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

for participation by medical providers, only with the prior written approval of the Illinois Department.

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

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

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

or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after the effective date of this amendatory Act of 1984, the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than

every 30 days as required by Section 5-5.12.

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

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after July 22, 2013~~,~~ (the effective date of Public Act 98-104), establish procedures to permit skilled care facilities licensed under the Nursing Home Care Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or structural changes to its information technology platforms are implemented.

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after August 15, 2014 (the effective date of Public Act 98-963) ~~this amendatory Act of the 98th General Assembly~~, establish procedures to permit ID/DD facilities licensed under the ID/DD Community Care Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or

structural changes to its information technology platforms are implemented.

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

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

Enrollment of a vendor shall be subject to a provisional period and shall be conditional for one year. During the period of conditional enrollment, the Department may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the medical assistance program without cause. 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 a recipient received retroactive eligibility, claims must be

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

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

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

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

The Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight. The Illinois Department shall develop, in cooperation with other State departments and agencies, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. At a minimum, and to the extent necessary to provide data sharing, the Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with

federal agencies and departments, including but not limited to: the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.

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

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

recipient's medical prognosis, the extent of the recipient's needs, and the requirements and costs for maintaining such equipment. Subject to prior approval, such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department.

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

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

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

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

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

(c) current rate structures and proposed changes in

those rate structures for the various medical vendors; and

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

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

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

On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with

Section 5-5e.

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

(Source: P.A. 97-48, eff. 6-28-11; 97-638, eff. 1-1-12; 97-689, eff. 6-14-12; 97-1061, eff. 8-24-12; 98-104, Article 9, Section 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 98-963, eff. 8-15-14; revised 10-2-14.)

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