AN ACT concerning public aid.

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

ARTICLE 2.

Section 2-5. The Illinois Public Aid Code is amended by changing Section 5-5 as follows:

(305 ILCS 5/5-5)

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 individuals, 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; (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 disease ~~anemia~~; (16.5) services performed by a chiropractic physician licensed under the Medical Practice Act of 1987 and acting within the scope of his or her license, including, but not limited to, chiropractic manipulative treatment; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State. 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, reproductive health care that is otherwise legal in Illinois shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article.

Notwithstanding any other provision of this Section, all tobacco cessation medications approved by the United States Food and Drug Administration and all individual and group tobacco cessation counseling services and telephone-based

counseling services and tobacco cessation medications provided through the Illinois Tobacco Quitline shall be covered under the medical assistance program for persons who are otherwise eligible for assistance under this Article. The Department shall comply with all federal requirements necessary to obtain federal financial participation, as specified in 42 CFR 433.15(b)(7), for telephone-based counseling services provided through the Illinois Tobacco Quitline, including, but not limited to: (i) entering into a memorandum of understanding or interagency agreement with the Department of Public Health, as administrator of the Illinois Tobacco Quitline; and (ii) developing a cost allocation plan for Medicaid-allowable Illinois Tobacco Quitline services in accordance with 45 CFR 95.507. The Department shall submit the memorandum of understanding or interagency agreement, the cost allocation plan, and all other necessary documentation to the Centers for Medicare and Medicaid Services for review and approval. Coverage under this paragraph shall be contingent upon federal approval.

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.

On and after July 1, 2018, the Department of Healthcare and Family Services shall provide dental services to any adult who is otherwise eligible for assistance under the medical assistance program. As used in this paragraph, "dental services" means diagnostic, preventative, restorative, or corrective procedures, including procedures and services for the prevention and treatment of periodontal disease and dental caries disease, provided by an individual who is licensed to practice dentistry or dental surgery or who is under the supervision of a dentist in the practice of his or her profession.

On and after July 1, 2018, targeted dental services, as set forth in Exhibit D of the Consent Decree entered by the United States District Court for the Northern District of Illinois, Eastern Division, in the matter of Memisovski v. Maram, Case No. 92 C 1982, that are provided to adults under the medical assistance program shall be established at no less than the rates set forth in the "New Rate" column in Exhibit D of the Consent Decree for targeted dental services that are provided to persons under the age of 18 under the medical assistance program.

Subject to federal approval, on and after January 1, 2025, the rates paid for sedation evaluation and the provision of

deep sedation and intravenous sedation for the purpose of dental services shall be increased by 33% above the rates in effect on December 31, 2024. The rates paid for nitrous oxide sedation shall not be impacted by this paragraph and shall remain the same as the rates in effect on December 31, 2024.

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.

Subject to appropriation and to federal approval, the Department shall file administrative rules updating the Handicapping Labio-Lingual Deviation orthodontic scoring tool by January 1, 2025, or as soon as practicable.

On and after January 1, 2022, the Department of Healthcare and Family Services shall administer and regulate a school-based dental program that allows for the out-of-office delivery of preventative dental services in a school setting

to children under 19 years of age. The Department shall establish, by rule, guidelines for participation by providers and set requirements for follow-up referral care based on the requirements established in the Dental Office Reference Manual published by the Department that establishes the requirements for dentists participating in the All Kids Dental School Program. Every effort shall be made by the Department when developing the program requirements to consider the different geographic differences of both urban and rural areas of the State for initial treatment and necessary follow-up care. No provider shall be charged a fee by any unit of local government to participate in the school-based dental program administered by the Department. Nothing in this paragraph shall be construed to limit or preempt a home rule unit's or school district's authority to establish, change, or administer a school-based dental program in addition to, or independent of, the school-based dental program administered by the Department.

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 individuals 35 years of age or older who are eligible for medical assistance under this Article, as follows:

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

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

(C) A mammogram at the age and intervals considered medically necessary by the individual's health care provider for individuals 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 and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when medically necessary as determined by a physician licensed to practice medicine in all of its branches.

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

(F) A diagnostic mammogram when medically necessary, as determined by a physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant.

(G) Molecular breast imaging (MBI) and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when medically necessary as determined by a physician licensed to practice medicine in all of its branches, advanced practice registered nurse, or physician assistant.

The Department shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided under this paragraph; except that this sentence does not apply to coverage of diagnostic mammograms to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to Section 223 of the Internal Revenue Code (26 U.S.C. 223).

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:

"Diagnostic mammogram" means a mammogram obtained using diagnostic mammography.

"Diagnostic mammography" means a method of screening that

is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.

"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 and includes breast tomosynthesis.

"Breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover breast

tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this paragraph.

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

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 and, after January 1, 2023 (the effective date of Public Act 102-1018), breast tomosynthesis.

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

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

cancer treatment quality program.

The Department shall convene an expert panel, including representatives of hospitals, free-standing breast cancer treatment centers, breast cancer quality organizations, and doctors, including radiologists that are trained in all forms of FDA-approved breast imaging technologies, breast surgeons, reconstructive breast surgeons, oncologists, and primary care providers to establish quality standards for breast cancer treatment.

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. By January 1, 2016, the Department shall report to the General Assembly on the status of the provision set forth in this paragraph.

The Department shall establish a methodology to remind individuals 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 work with experts in breast cancer outreach and patient navigation to optimize these reminders and shall establish a methodology for evaluating their effectiveness and modifying the methodology based on the evaluation.

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. On or after July 1, 2016, the pilot program shall be expanded to include one site in western Illinois, one site in southern Illinois, one site in central Illinois, and 4 sites within metropolitan Chicago. 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.

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

in-network covered benefit.

The Department shall provide coverage and reimbursement for a human papillomavirus (HPV) vaccine that is approved for marketing by the federal Food and Drug Administration for all persons between the ages of 9 and 45. Subject to federal approval, the Department shall provide coverage and reimbursement for a human papillomavirus (HPV) vaccine for persons of the age of 46 and above who have been diagnosed with cervical dysplasia with a high risk of recurrence or progression. The Department shall disallow any preauthorization requirements for the administration of the human papillomavirus (HPV) vaccine.

On or after July 1, 2022, individuals who are otherwise eligible for medical assistance under this Article shall receive coverage for perinatal depression screenings for the 12-month period beginning on the last day of their pregnancy. Medical assistance coverage under this paragraph shall be conditioned on the use of a screening instrument approved by the Department.

Any medical or health care provider shall immediately recommend, to any pregnant individual who is being provided prenatal services and is suspected of having a substance use disorder as defined in the Substance Use Disorder Act, referral to a local substance use disorder treatment program 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 individuals under this Code shall receive information from the Department on the availability of services under any program providing case management services for addicted individuals, including information on appropriate referrals for other social services that may be needed by addicted individuals 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 the recipient's 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 September 16, 1984 (the effective date of Public Act 83-1439), 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.

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, by July 1, 2016, test the viability of the new system and implement any necessary operational or structural changes to its information technology platforms in order to allow for the direct acceptance and payment of nursing home claims.

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), establish procedures to permit ID/DD facilities licensed under the ID/DD Community Care Act and MC/DD facilities licensed under the MC/DD 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 the 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 120 calendar days of receipt by the facility of required prescreening information, new admissions with associated admission documents shall be submitted through the Medical

Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System 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-adjudicated, 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. Notwithstanding any provision of Section 5-5f to the contrary, the Department may, by rule, exempt certain replacement wheelchair parts from prior approval and, for wheelchairs,

wheelchair parts, wheelchair accessories, and related seating and positioning items, determine the wholesale price by methods other than actual acquisition costs.

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

In order to promote environmental responsibility, meet the needs of recipients and enrollees, and achieve significant cost savings, the Department, or a managed care organization under contract with the Department, may provide recipients or managed care enrollees who have a prescription or Certificate of Medical Necessity access to refurbished durable medical equipment under this Section (excluding prosthetic and orthotic devices as defined in the Orthotics, Prosthetics, and Pedorthics Practice Act and complex rehabilitation technology products and associated services) through the State's assistive technology program's reutilization program, using staff with the Assistive Technology Professional (ATP) Certification if the refurbished durable medical equipment: (i) is available; (ii) is less expensive, including shipping costs, than new durable medical equipment of the same type;

(iii) is able to withstand at least 3 years of use; (iv) is cleaned, disinfected, sterilized, and safe in accordance with federal Food and Drug Administration regulations and guidance governing the reprocessing of medical devices in health care settings; and (v) equally meets the needs of the recipient or enrollee. The reutilization program shall confirm that the recipient or enrollee is not already in receipt of the same or similar equipment from another service provider, and that the refurbished durable medical equipment equally meets the needs of the recipient or enrollee. Nothing in this paragraph shall be construed to limit recipient or enrollee choice to obtain new durable medical equipment or place any additional prior authorization conditions on enrollees of managed care organizations.

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 requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act, and filing 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.

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.

Notwithstanding any other provision of this Code to the contrary, on or after July 1, 2015, all FDA-approved forms of medication assisted treatment prescribed for the treatment of alcohol dependence or treatment of opioid dependence shall be

covered under both fee-for-service and managed care medical assistance programs for persons who are otherwise eligible for medical assistance under this Article and shall not be subject to any (1) utilization control, other than those established under the American Society of Addiction Medicine patient placement criteria, (2) prior authorization mandate, (3) lifetime restriction limit mandate, or (4) limitations on dosage.

On or after July 1, 2015, opioid antagonists prescribed for the treatment of an opioid overdose, including the medication product, administration devices, and any pharmacy fees or hospital fees related to the dispensing, distribution, and administration of the opioid antagonist, shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article. As used in this Section, "opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration. The Department shall not impose a copayment on the coverage provided for naloxone hydrochloride under the medical assistance program.

Upon federal approval, the Department shall provide coverage and reimbursement for all drugs that are approved for marketing by the federal Food and Drug Administration and that

are recommended by the federal Public Health Service or the United States Centers for Disease Control and Prevention for pre-exposure prophylaxis and related pre-exposure prophylaxis services, including, but not limited to, HIV and sexually transmitted infection screening, treatment for sexually transmitted infections, medical monitoring, assorted labs, and counseling to reduce the likelihood of HIV infection among individuals who are not infected with HIV but who are at high risk of HIV infection.

A federally qualified health center, as defined in Section 1905(l)(2)(B) of the federal Social Security Act, shall be reimbursed by the Department in accordance with the federally qualified health center's encounter rate for services provided to medical assistance recipients that are performed by a dental hygienist, as defined under the Illinois Dental Practice Act, working under the general supervision of a dentist and employed by a federally qualified health center.

Within 90 days after October 8, 2021 (the effective date of Public Act 102-665), the Department shall seek federal approval of a State Plan amendment to expand coverage for family planning services that includes presumptive eligibility to individuals whose income is at or below 208% of the federal poverty level. Coverage under this Section shall be effective beginning no later than December 1, 2022.

Subject to approval by the federal Centers for Medicare and Medicaid Services of a Title XIX State Plan amendment

electing the Program of All-Inclusive Care for the Elderly (PACE) as a State Medicaid option, as provided for by Subtitle I (commencing with Section 4801) of Title IV of the Balanced Budget Act of 1997 (Public Law 105-33) and Part 460 (commencing with Section 460.2) of Subchapter E of Title 42 of the Code of Federal Regulations, PACE program services shall become a covered benefit of the medical assistance program, subject to criteria established in accordance with all applicable laws.

Notwithstanding any other provision of this Code, community-based pediatric palliative care from a trained interdisciplinary team shall be covered under the medical assistance program as provided in Section 15 of the Pediatric Palliative Care Act.

Notwithstanding any other provision of this Code, within 12 months after June 2, 2022 (the effective date of Public Act 102-1037) and subject to federal approval, acupuncture services performed by an acupuncturist licensed under the Acupuncture Practice Act who is acting within the scope of his or her license shall be covered under the medical assistance program. The Department shall apply for any federal waiver or State Plan amendment, if required, to implement this paragraph. The Department may adopt any rules, including standards and criteria, necessary to implement this paragraph.

Notwithstanding any other provision of this Code, the medical assistance program shall, subject to federal approval,

reimburse hospitals for costs associated with a newborn screening test for the presence of metachromatic leukodystrophy, as required under the Newborn Metabolic Screening Act, at a rate not less than the fee charged by the Department of Public Health. Notwithstanding any other provision of this Code, the medical assistance program shall, subject to appropriation and federal approval, also reimburse hospitals for costs associated with all newborn screening tests added on and after August 9, 2024 (the effective date of Public Act 103-909) to the Newborn Metabolic Screening Act and required to be performed under that Act at a rate not less than the fee charged by the Department of Public Health. The Department shall seek federal approval before the implementation of the newborn screening test fees by the Department of Public Health.

Notwithstanding any other provision of this Code, beginning on January 1, 2024, subject to federal approval, cognitive assessment and care planning services provided to a person who experiences signs or symptoms of cognitive impairment, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article.

Notwithstanding any other provision of this Code, medically necessary reconstructive services that are intended to restore physical appearance shall be covered under the

medical assistance program for persons who are otherwise eligible for medical assistance under this Article. As used in this paragraph, "reconstructive services" means treatments performed on structures of the body damaged by trauma to restore physical appearance.

Subject to federal approval, for dates of services on and after January 1, 2026, over-the-counter choline dietary supplements for pregnant persons shall be covered under the medical assistance program.

(Source: P.A. 103-102, Article 15, Section 15-5, eff. 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff. 1-1-24; 103-593, Article 5, Section 5-5, eff. 6-7-24; 103-593, Article 90, Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24; 103-808, eff. 1-1-26; 103-909, eff. 8-9-24; 103-1040, eff. 8-9-24; 104-9, eff. 6-16-25; 104-417, eff. 8-15-25.)

ARTICLE 6.

Section 6-5. The Illinois Public Aid Code is amended by adding Article V-J as follows:

(305 ILCS 5/Art. V-J heading new)

ARTICLE V-J. DISTRESSED HOSPITAL LOAN PROGRAM

(305 ILCS 5/5J-1 new)

Sec. 5J-1. References to Article. This Article may be referred to as the Distressed Hospital Loan Program Law.

(305 ILCS 5/5J-5 new)

Sec. 5J-5. Distressed Hospital Loan Program. The Distressed Hospital Loan Program is created. The purpose of the Program is to provide, subject to appropriation and the availability of funds, interest-free cash flow loans to public, not-for-profit, and for-profit hospitals in significant financial distress to prevent the closure of or to facilitate the reopening of those hospitals.

(305 ILCS 5/5J-10 new)

Sec. 5J-10. Definitions. As used in this Article:

"Closed hospital" means a hospital that closed after January 1, 2019.

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

"Program" means the Distressed Hospital Loan Program.

"Public hospital" means a hospital that is licensed by the Hospital Licensing Act and is either owned or operated by a governmental body in Illinois, excluding a State agency, a State university, or a county with a population of 3,000,000 or more.

(305 ILCS 5/5J-15 new)

Sec. 5J-15. Administration. The Department shall administer the Distressed Hospital Loan Program in coordination with the Department of Public Health and the Governor's Office of Management and Budget. The Department shall adopt rules to implement this Program.

(305 ILCS 5/5J-18 new)

Sec. 5J-18. Application requirements. A hospital applying for aid under this Program shall provide the Department with financial information, in a format determined by the Department, demonstrating the hospital's need for bridge financing due to financial hardship.

(1) Before receiving bridge financing under this Program, an eligible hospital shall submit a plan to the Department, with projections detailing the uses of the proposed loan and a structured plan proposed by the hospital's governing body to regain financial viability and continue operations.

(2) Before issuing a loan under this Program, the Department shall review the plan submitted by an eligible hospital and make a determination both that the plan is viable and that there is a reasonable likelihood that the hospital will be able to regain financial viability, continue to operate as a hospital, and be able to repay the loan. The Department shall not issue a loan award if the Department is unable to make these determinations.

(3) All funds loaned in accordance with this Article shall be used as described in the application approved by the Department, which shall be incorporated into any resulting loan agreement. Any misused funds shall be recouped by the Department subject to the recoupment methods under Section 5J-25. In addition to any other remedies provided for by law and without sending a notice of liability, the Department may withhold, as payment of any amounts due and owing as repayment of loans issued in accordance with this Article, reimbursements or other amounts otherwise payable by the Department to the loan recipient, including, but not limited to, amounts otherwise payable from a managed care organization performing duties under contract with the Department.

(305 ILCS 5/5J-20 new)

Sec. 5J-20. Application evaluation.

(a) In collaboration with the Governor's Office of Management and Budget and the Department of Public Health, the Department shall develop a methodology to evaluate a hospital's application for a loan through the Program.

(b) The methodology shall consider factors including, but not limited to, whether the hospital is in financial distress as solely determined by the State; whether the hospital is small, rural, a safety-net hospital, a critical access hospital, a trauma center, an urban hospital providing access

for an underserved area, a hospital that serves a disproportionate share of Medicaid patients, or serving a rural catchment area; and whether closure of the hospital or service line reduction as a result of the financial distress would significantly impact access to services in the hospital's health service area.

(c) The methodology for determining financial distress may consider such factors as the hospital's prior and projected performance on financial metrics, including the amount of cash on hand, and whether the hospital has experienced, or is projected to experience, negative operating margins.

(d) Subject to appropriation and the availability of funds, any loan to a hospital with an approved loan application shall be issued as soon as reasonably practicable following approval of an application. Approved applications shall receive funding on a first-come, first-served basis until funding appropriated by the General Assembly for this purpose has been expended. The Department maintains discretion to determine the amount of a loan approved for a hospital and may approve less than the amount requested by a hospital. The Department may consider the amount of appropriations available to this Program in the exercise of its discretion.

(e) Hospitals ineligible for State assistance under the Program include:

(1) Hospitals that belong to integrated health care systems with more than 3 separately licensed hospital

facilities.

(2) A hospital that maintains unpaid hospital assessment liability owed to the State and either does not have a negotiated tax repayment agreement with the State or is delinquent under an existing negotiated assessment repayment agreement.

(3) A hospital that is not current on a repayment schedule for a prior advance issued in accordance with 89 Ill. Adm. Code 140.71.

(4) A hospital that has not provided required reporting on its finances as mandated by State law or administrative rule.

(5) A hospital that is subject to a stop payment order, as defined by the Grant Accountability and Transparency Act, with the State for any reason.

(6) A hospital that has been under investigation or been issued an immediate jeopardy by the Centers for Medicare and Medicaid Services in the prior 12 months from the time of loan application.

(f) The Department shall give preference to not-for-profit and public hospitals. Hospitals owned and operated by a for-profit entity shall be subject to a maximum funding limit, expedited repayment time frames, and additional financial and operational transparency requirements as defined in rule.

(g) The Department shall determine the application process, underwriting review, and methodology for approval and

distribution of the loans under the Program.

(h) The Department shall have the authority to determine service provision requirements in approving, and for the duration of, loans to eligible hospitals. In making its determination, the Department shall consider the impact of any changes to the hospital's service delivery or access to necessary medical care, particularly for beneficiaries of the State's medical assistance Program.

(i) The application process shall allow for at least 30 days for the Department to issue an initial response to any loan application.

(305 ILCS 5/5J-25 new)

Sec. 5J-25. Repayment agreement.

(a) A hospital shall be required to enter into a repayment agreement with the Department to execute the approved loan. Terms must include, but are not limited to, monthly repayments of the loan beginning no later than 18 months after receipt of the loan and discharge of the loan within 36 months of the date of the loan.

(b) Notwithstanding any other law and to the extent permissible under federal rules, security for the cash flow loans in this Article shall, at a minimum, include reimbursements due to the hospital from the Department, including, but not limited to, any reimbursements under this Code. The repayment agreement may provide for additional

security for any cash flow loans under this Article.

(c) If the hospital provider fails to comply with the repayment terms of the agreement, the remaining balance of the loan shall be immediately recouped from reimbursements or other amounts otherwise payable by the Department to the loan recipient, including, but not limited to, amounts otherwise payable from a managed care organization performing duties under contract with the Department. The Department may also recoup amounts otherwise payable by any State agency to the provider, including, but not limited to, State grants and grant appropriations, and apply such amounts as repayment of the unpaid advance. If such reimbursements or other amounts otherwise payable to the loan recipient are insufficient for complete recovery, the remaining balance shall become immediately due and payable by check to the Department of Healthcare and Family Services. Failure by the provider to remit such check shall result in the Department pursuing other collection methods.

(d) Any unpaid loan under this Article shall become a lien upon the assets of the hospital that received the loan. If any hospital provider, outside the usual course of its business, sells or transfers the major part of any one or more of (A) the real property and improvements, (B) the machinery and equipment, or (C) the furniture or fixtures, of any hospital that is subject to the provisions of this Article, the seller or transferor shall pay the Department the amount of any loan,

penalty, and interest (if any) due from it under this Article up to the date of the sale or transfer. The Department may, in its discretion, foreclose on such a lien, but shall do so in a manner that is consistent with Section 5e of the Retailers' Occupation Tax Act. If the seller or transferor fails to pay any loan, penalty, and interest (if any) due, the purchaser or transferee of such asset shall be liable for the amount of the loan, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the loan, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee or until the purchaser or transferee receives from the Department a certificate showing that such loan, penalty, and interest have been paid or a certificate from the Department showing that no loan, penalty, or interest is due from the seller or transferor under this Article.

(e) If a hospital provider fails to pay any monthly installment repayments, there shall, unless waived by the Department for reasonable cause, be added to the loan repayment obligation a penalty equal to the lesser of (i) 5% of the amount of the installment not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each 30-day period thereafter or (ii) 100% of the installment amount not paid on or before the due date.

(305 ILCS 5/5J-30 new)

Sec. 5J-30. Distressed Hospital Loan Program Fund.

(a) The Distressed Hospital Loan Program Fund is created as a special fund in the State treasury.

(b) Subject to appropriation, the Department may make secured and unsecured loans from amounts in the Distressed Hospital Loan Program Fund to a hospital, or a governmental entity representing a closed hospital, for purposes of preventing the hospital's closure in accordance with the provisions of this Article.

(c) On January 1, 2027, or as soon thereafter as practical, the State Comptroller shall direct and the State Treasurer shall transfer, at the direction of the Director of the Department, an amount not to exceed $85,000,000 from the Healthcare Provider Relief Fund to the Distressed Hospital Loan Program Fund.

(d) All moneys accruing to the Department under this Article from any source, including, but not limited to, all amounts repaid under the terms of any loan agreements, shall be deposited into the Fund.

(e) On June 30, 2033, or as soon thereafter as practical, the State Comptroller shall direct and the State Treasurer shall transfer the remaining balance in the Distressed Hospital Loan Program Fund to the Healthcare Provider Relief Fund. Upon completion of the transfers, the Distressed

Hospital Loan Program Fund is dissolved and any outstanding obligations or liabilities of the Fund pass to the Healthcare Provider Relief Fund. The Department shall deposit all subsequent loan repayments or medical assistance program or other reimbursements withheld for due cause in accordance with this Article into the Healthcare Provider Relief Fund.

(f) The Department may require any hospital receiving a loan under this Article to provide the Department with an independent financial audit of the hospital's operations for any fiscal year in which a loan is outstanding.

(305 ILCS 5/5J-35 new)

Sec. 5J-35. Implementation. The Program described in this Article shall be operative on and after January 1, 2027 and shall be implemented upon administrative rules being in effect.

(305 ILCS 5/5J-40 new)

Sec. 5J-40. Repealer. This Article is repealed on June 30, 2033.

Section 6-70. The State Finance Act is amended by adding Section 5.1038 as follows:

(30 ILCS 105/5.1038 new)

Sec. 5.1038. The Distressed Hospital Loan Program Fund.

This Section is repealed June 30, 2033.

Section 6-72. The Illinois Administrative Procedure Act is amended by adding Section 5-45.71 as follows:

(5 ILCS 100/5-45.71 new)

Sec. 5-45.71. Emergency rulemaking; Health Facilities and Services Review Board. To provide for the expeditious and timely implementation of the changes made by this amendatory Act of the 104th General Assembly to Section 13 of the Illinois Health Facilities Planning Act, emergency rules may be adopted in accordance with Section 5-45 by the Health Facilities and Services Review Board. The adoption of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed one year after the effective date of this amendatory Act of the 104th General Assembly.

Section 6-73. The Freedom of Information Act is amended by changing Section 7.5 as follows:

(5 ILCS 140/7.5)

(Text of Section before amendment by P.A. 104-441 and 104-457)

Sec. 7.5. Statutory exemptions. To the extent provided for by the statutes referenced below, the following shall be

exempt from inspection and copying:

(a) All information determined to be confidential under Section 4002 of the Technology Advancement and Development Act.

(b) Library circulation and order records identifying library users with specific materials under the Library Records Confidentiality Act.

(c) Applications, related documents, and medical records received by the Experimental Organ Transplantation Procedures Board and any and all documents or other records prepared by the Experimental Organ Transplantation Procedures Board or its staff relating to applications it has received.

(d) Information and records held by the Department of Public Health and its authorized representatives relating to known or suspected cases of sexually transmitted infection or any information the disclosure of which is restricted under the Illinois Sexually Transmitted Infection Control Act.

(e) Information the disclosure of which is exempted under Section 30 of the Radon Industry Licensing Act.

(f) Firm performance evaluations under Section 55 of the Architectural, Engineering, and Land Surveying Qualifications Based Selection Act.

(g) Information the disclosure of which is restricted and exempted under Section 50 of the Illinois Prepaid

Tuition Act.

(h) Information the disclosure of which is exempted under the State Officials and Employees Ethics Act, and records of any lawfully created State or local inspector general's office that would be exempt if created or obtained by an Executive Inspector General's office under that Act.

(i) Information contained in a local emergency energy plan submitted to a municipality in accordance with a local emergency energy plan ordinance that is adopted under Section 11-21.5-5 of the Illinois Municipal Code.

(j) Information and data concerning the distribution of surcharge moneys collected and remitted by carriers under the Emergency Telephone System Act.

(k) Law enforcement officer identification information or driver identification information compiled by a law enforcement agency or the Department of Transportation under Section 11-212 of the Illinois Vehicle Code.

(l) Records and information provided to a residential health care facility resident sexual assault and death review team or the Executive Council under the Abuse Prevention Review Team Act.

(m) Information provided to the predatory lending database created pursuant to Article 3 of the Residential Real Property Disclosure Act, except to the extent authorized under that Article.

(n) Defense budgets and petitions for certification of compensation and expenses for court appointed trial counsel as provided under Sections 10 and 15 of the Capital Crimes Litigation Act (repealed). This subsection (n) shall apply until the conclusion of the trial of the case, even if the prosecution chooses not to pursue the death penalty prior to trial or sentencing.

(o) Information that is prohibited from being disclosed under Section 4 of the Illinois Health and Hazardous Substances Registry Act.

(p) Security portions of system safety program plans, investigation reports, surveys, schedules, lists, data, or information compiled, collected, or prepared by or for the Department of Transportation under Sections 2705-300 and 2705-616 of the Department of Transportation Law of the Civil Administrative Code of Illinois, the Regional Transportation Authority under Section 2.11 of the Regional Transportation Authority Act, or the St. Clair County Transit District under the Bi-State Transit Safety Act (repealed).

(q) Information prohibited from being disclosed by the Personnel Record Review Act.

(r) Information prohibited from being disclosed by the Illinois School Student Records Act.

(s) Information the disclosure of which is restricted under Section 5-108 of the Public Utilities Act.

(t) (Blank).

(u) Records and information provided to an independent team of experts under the Developmental Disability and Mental Health Safety Act (also known as Brian's Law).

(v) Names and information of people who have applied for or received Firearm Owner's Identification Cards under the Firearm Owners Identification Card Act or applied for or received a concealed carry license under the Firearm Concealed Carry Act, unless otherwise authorized by the Firearm Concealed Carry Act; and databases under the Firearm Concealed Carry Act, records of the Concealed Carry Licensing Review Board under the Firearm Concealed Carry Act, and law enforcement agency objections under the Firearm Concealed Carry Act.

(v-5) Records of the Firearm Owner's Identification Card Review Board that are exempted from disclosure under Section 10 of the Firearm Owners Identification Card Act.

(w) Personally identifiable information which is exempted from disclosure under subsection (g) of Section 19.1 of the Toll Highway Act.

(x) Information which is exempted from disclosure under Section 5-1014.3 of the Counties Code or Section 8-11-21 of the Illinois Municipal Code.

(y) Confidential information under the Adult Protective Services Act and its predecessor enabling statute, the Elder Abuse and Neglect Act, including

information about the identity and administrative finding against any caregiver of a verified and substantiated decision of abuse, neglect, or financial exploitation of an eligible adult maintained in the Registry established under Section 7.5 of the Adult Protective Services Act.

(z) Records and information provided to a fatality review team or the Illinois Fatality Review Team Advisory Council under Section 15 of the Adult Protective Services Act.

(aa) Information which is exempted from disclosure under Section 2.37 of the Wildlife Code.

(bb) Information which is or was prohibited from disclosure by the Juvenile Court Act of 1987.

(cc) Recordings made under the Law Enforcement Officer-Worn Body Camera Act, except to the extent authorized under that Act.

(dd) Information that is prohibited from being disclosed under Section 45 of the Condominium and Common Interest Community Ombudsperson Act.

(ee) Information that is exempted from disclosure under Section 30.1 of the Pharmacy Practice Act.

(ff) Information that is exempted from disclosure under the Revised Uniform Unclaimed Property Act.

(gg) Information that is prohibited from being disclosed under Section 7-603.5 of the Illinois Vehicle Code.

(hh) Records that are exempt from disclosure under Section 1A-16.7 of the Election Code.

(ii) Information which is exempted from disclosure under Section 2505-800 of the Department of Revenue Law of the Civil Administrative Code of Illinois.

(jj) Information and reports that are required to be submitted to the Department of Labor by registering day and temporary labor service agencies but are exempt from disclosure under subsection (a-1) of Section 45 of the Day and Temporary Labor Services Act.

(kk) Information prohibited from disclosure under the Seizure and Forfeiture Reporting Act.

(ll) Information the disclosure of which is restricted and exempted under Section 5-30.8 of the Illinois Public Aid Code.

(mm) Records that are exempt from disclosure under Section 4.2 of the Crime Victims Compensation Act.

(nn) Information that is exempt from disclosure under Section 70 of the Higher Education Student Assistance Act.

(oo) Communications, notes, records, and reports arising out of a peer support counseling session prohibited from disclosure under the First Responders Suicide Prevention Act.

(pp) Names and all identifying information relating to an employee of an emergency services provider or law enforcement agency under the First Responders Suicide

Prevention Act.

(qq) Information and records held by the Department of Public Health and its authorized representatives collected under the Reproductive Health Act.

(rr) Information that is exempt from disclosure under the Cannabis Regulation and Tax Act.

(ss) Data reported by an employer to the Department of Human Rights pursuant to Section 2-108 of the Illinois Human Rights Act.

(tt) Recordings made under the Children's Advocacy Center Act, except to the extent authorized under that Act.

(uu) Information that is exempt from disclosure under Section 50 of the Sexual Assault Evidence Submission Act.

(vv) Information that is exempt from disclosure under subsections (f) and (j) of Section 5-36 of the Illinois Public Aid Code.

(ww) Information that is exempt from disclosure under Section 16.8 of the State Treasurer Act.

(xx) Information that is exempt from disclosure or information that shall not be made public under the Illinois Insurance Code.

(yy) Information prohibited from being disclosed under the Illinois Educational Labor Relations Act.

(zz) Information prohibited from being disclosed under the Illinois Public Labor Relations Act.

(aaa) Information prohibited from being disclosed under Section 1-167 of the Illinois Pension Code.

(bbb) Information that is prohibited from disclosure by the Illinois Police Training Act and the Illinois State Police Act.

(ccc) Records exempt from disclosure under Section 2605-304 of the Illinois State Police Law of the Civil Administrative Code of Illinois.

(ddd) Information prohibited from being disclosed under Section 35 of the Address Confidentiality for Victims of Domestic Violence, Sexual Assault, Human Trafficking, or Stalking Act.

(eee) Information prohibited from being disclosed under subsection (b) of Section 75 of the Domestic Violence Fatality Review Act.

(fff) Images from cameras under the Expressway Camera Act and all automated license plate reader (ALPR) information used and collected by the Illinois State Police. "ALPR information" means information gathered by an ALPR or created from the analysis of data generated by an ALPR. This subsection (fff) is inoperative on and after July 1, 2028.

(ggg) Information prohibited from disclosure under paragraph (3) of subsection (a) of Section 14 of the Nurse Agency Licensing Act.

(hhh) Information submitted to the Illinois State

Police in an affidavit or application for an assault weapon endorsement, assault weapon attachment endorsement, .50 caliber rifle endorsement, or .50 caliber cartridge endorsement under the Firearm Owners Identification Card Act.

(iii) Data exempt from disclosure under Section 50 of the School Safety Drill Act.

(jjj) Information exempt from disclosure under Section 30 of the Insurance Data Security Law.

(kkk) Confidential business information prohibited from disclosure under Section 45 of the Paint Stewardship Act.

(lll) Data exempt from disclosure under Section 2-3.196 of the School Code.

(mmm) Information prohibited from being disclosed under subsection (e) of Section 1-129 of the Illinois Power Agency Act.

(nnn) Materials received by the Department of Commerce and Economic Opportunity that are confidential under the Music and Musicians Tax Credit and Jobs Act.

(ooo) Data or information provided pursuant to Section 20 of the Statewide Recycling Needs and Assessment Act.

(ppp) Information that is exempt from disclosure under Section 28-11 of the Lawful Health Care Activity Act.

(qqq) Information that is exempt from disclosure under Section 7-101 of the Illinois Human Rights Act.

(rrr) Information prohibited from being disclosed under Section 4-2 of the Uniform Money Transmission Modernization Act.

(sss) Information exempt from disclosure under Section 40 of the Student-Athlete Endorsement Rights Act.

(ttt) Audio recordings made under Section 30 of the Illinois State Police Act, except to the extent authorized under that Section.

(uuu) Information prohibited from being disclosed under Section 30-5 of the Digital Assets Regulation Act.

(Source: P.A. 103-8, eff. 6-7-23; 103-34, eff. 6-9-23; 103-142, eff. 1-1-24; 103-372, eff. 1-1-24; 103-472, eff. 8-1-24; 103-508, eff. 8-4-23; 103-580, eff. 12-8-23; 103-592, eff. 6-7-24; 103-605, eff. 7-1-24; 103-636, eff. 7-1-24; 103-724, eff. 1-1-25; 103-786, eff. 8-7-24; 103-859, eff. 8-9-24; 103-991, eff. 8-9-24; 103-1049, eff. 8-9-24; 103-1081, eff. 3-21-25; 104-10, eff. 6-16-25; 104-18, eff. 6-30-25; 104-417, eff. 8-15-25; 104-428, eff. 8-18-25; revised 9-10-25.)

(Text of Section after amendment by P.A. 104-457 but before 104-441)

Sec. 7.5. Statutory exemptions. To the extent provided for by the statutes referenced below, the following shall be exempt from inspection and copying:

(a) All information determined to be confidential

under Section 4002 of the Technology Advancement and Development Act.

(b) Library circulation and order records identifying library users with specific materials under the Library Records Confidentiality Act.

(c) Applications, related documents, and medical records received by the Experimental Organ Transplantation Procedures Board and any and all documents or other records prepared by the Experimental Organ Transplantation Procedures Board or its staff relating to applications it has received.

(d) Information and records held by the Department of Public Health and its authorized representatives relating to known or suspected cases of sexually transmitted infection or any information the disclosure of which is restricted under the Illinois Sexually Transmitted Infection Control Act.

(e) Information the disclosure of which is exempted under Section 30 of the Radon Industry Licensing Act.

(f) Firm performance evaluations under Section 55 of the Architectural, Engineering, and Land Surveying Qualifications Based Selection Act.

(g) Information the disclosure of which is restricted and exempted under Section 50 of the Illinois Prepaid Tuition Act.

(h) Information the disclosure of which is exempted

under the State Officials and Employees Ethics Act, and records of any lawfully created State or local inspector general's office that would be exempt if created or obtained by an Executive Inspector General's office under that Act.

(i) Information contained in a local emergency energy plan submitted to a municipality in accordance with a local emergency energy plan ordinance that is adopted under Section 11-21.5-5 of the Illinois Municipal Code.

(j) Information and data concerning the distribution of surcharge moneys collected and remitted by carriers under the Emergency Telephone System Act.

(k) Law enforcement officer identification information or driver identification information compiled by a law enforcement agency or the Department of Transportation under Section 11-212 of the Illinois Vehicle Code.

(l) Records and information provided to a residential health care facility resident sexual assault and death review team or the Executive Council under the Abuse Prevention Review Team Act.

(m) Information provided to the predatory lending database created pursuant to Article 3 of the Residential Real Property Disclosure Act, except to the extent authorized under that Article.

(n) Defense budgets and petitions for certification of compensation and expenses for court appointed trial

counsel as provided under Sections 10 and 15 of the Capital Crimes Litigation Act (repealed). This subsection (n) shall apply until the conclusion of the trial of the case, even if the prosecution chooses not to pursue the death penalty prior to trial or sentencing.

(o) Information that is prohibited from being disclosed under Section 4 of the Illinois Health and Hazardous Substances Registry Act.

(p) Security portions of system safety program plans, investigation reports, surveys, schedules, lists, data, or information compiled, collected, or prepared by or for the Department of Transportation under Sections 2705-300 and 2705-616 of the Department of Transportation Law of the Civil Administrative Code of Illinois, the Northern Illinois Transit Authority under Section 2.11 of the Northern Illinois Transit Authority Act, or the St. Clair County Transit District under the Bi-State Transit Safety Act (repealed).

(q) Information prohibited from being disclosed by the Personnel Record Review Act.

(r) Information prohibited from being disclosed by the Illinois School Student Records Act.

(s) Information the disclosure of which is restricted under Section 5-108 of the Public Utilities Act.

(t) (Blank).

(u) Records and information provided to an independent

team of experts under the Developmental Disability and Mental Health Safety Act (also known as Brian's Law).

(v) Names and information of people who have applied for or received Firearm Owner's Identification Cards under the Firearm Owners Identification Card Act or applied for or received a concealed carry license under the Firearm Concealed Carry Act, unless otherwise authorized by the Firearm Concealed Carry Act; and databases under the Firearm Concealed Carry Act, records of the Concealed Carry Licensing Review Board under the Firearm Concealed Carry Act, and law enforcement agency objections under the Firearm Concealed Carry Act.

(v-5) Records of the Firearm Owner's Identification Card Review Board that are exempted from disclosure under Section 10 of the Firearm Owners Identification Card Act.

(w) Personally identifiable information which is exempted from disclosure under subsection (g) of Section 19.1 of the Toll Highway Act.

(x) Information which is exempted from disclosure under Section 5-1014.3 of the Counties Code or Section 8-11-21 of the Illinois Municipal Code.

(y) Confidential information under the Adult Protective Services Act and its predecessor enabling statute, the Elder Abuse and Neglect Act, including information about the identity and administrative finding against any caregiver of a verified and substantiated

decision of abuse, neglect, or financial exploitation of an eligible adult maintained in the Registry established under Section 7.5 of the Adult Protective Services Act.

(z) Records and information provided to a fatality review team or the Illinois Fatality Review Team Advisory Council under Section 15 of the Adult Protective Services Act.

(aa) Information which is exempted from disclosure under Section 2.37 of the Wildlife Code.

(bb) Information which is or was prohibited from disclosure by the Juvenile Court Act of 1987.

(cc) Recordings made under the Law Enforcement Officer-Worn Body Camera Act, except to the extent authorized under that Act.

(dd) Information that is prohibited from being disclosed under Section 45 of the Condominium and Common Interest Community Ombudsperson Act.

(ee) Information that is exempted from disclosure under Section 30.1 of the Pharmacy Practice Act.

(ff) Information that is exempted from disclosure under the Revised Uniform Unclaimed Property Act.

(gg) Information that is prohibited from being disclosed under Section 7-603.5 of the Illinois Vehicle Code.

(hh) Records that are exempt from disclosure under Section 1A-16.7 of the Election Code.

(ii) Information which is exempted from disclosure under Section 2505-800 of the Department of Revenue Law of the Civil Administrative Code of Illinois.

(jj) Information and reports that are required to be submitted to the Department of Labor by registering day and temporary labor service agencies but are exempt from disclosure under subsection (a-1) of Section 45 of the Day and Temporary Labor Services Act.

(kk) Information prohibited from disclosure under the Seizure and Forfeiture Reporting Act.

(ll) Information the disclosure of which is restricted and exempted under Section 5-30.8 of the Illinois Public Aid Code.

(mm) Records that are exempt from disclosure under Section 4.2 of the Crime Victims Compensation Act.

(nn) Information that is exempt from disclosure under Section 70 of the Higher Education Student Assistance Act.

(oo) Communications, notes, records, and reports arising out of a peer support counseling session prohibited from disclosure under the First Responders Suicide Prevention Act.

(pp) Names and all identifying information relating to an employee of an emergency services provider or law enforcement agency under the First Responders Suicide Prevention Act.

(qq) Information and records held by the Department of

Public Health and its authorized representatives collected under the Reproductive Health Act.

(rr) Information that is exempt from disclosure under the Cannabis Regulation and Tax Act.

(ss) Data reported by an employer to the Department of Human Rights pursuant to Section 2-108 of the Illinois Human Rights Act.

(tt) Recordings made under the Children's Advocacy Center Act, except to the extent authorized under that Act.

(uu) Information that is exempt from disclosure under Section 50 of the Sexual Assault Evidence Submission Act.

(vv) Information that is exempt from disclosure under subsections (f) and (j) of Section 5-36 of the Illinois Public Aid Code.

(ww) Information that is exempt from disclosure under Section 16.8 of the State Treasurer Act.

(xx) Information that is exempt from disclosure or information that shall not be made public under the Illinois Insurance Code.

(yy) Information prohibited from being disclosed under the Illinois Educational Labor Relations Act.

(zz) Information prohibited from being disclosed under the Illinois Public Labor Relations Act.

(aaa) Information prohibited from being disclosed under Section 1-167 of the Illinois Pension Code.

(bbb) Information that is prohibited from disclosure by the Illinois Police Training Act and the Illinois State Police Act.

(ccc) Records exempt from disclosure under Section 2605-304 of the Illinois State Police Law of the Civil Administrative Code of Illinois.

(ddd) Information prohibited from being disclosed under Section 35 of the Address Confidentiality for Victims of Domestic Violence, Sexual Assault, Human Trafficking, or Stalking Act.

(eee) Information prohibited from being disclosed under subsection (b) of Section 75 of the Domestic Violence Fatality Review Act.

(fff) Images from cameras under the Expressway Camera Act and all automated license plate reader (ALPR) information used and collected by the Illinois State Police. "ALPR information" means information gathered by an ALPR or created from the analysis of data generated by an ALPR. This subsection (fff) is inoperative on and after July 1, 2028.

(ggg) Information prohibited from disclosure under paragraph (3) of subsection (a) of Section 14 of the Nurse Agency Licensing Act.

(hhh) Information submitted to the Illinois State Police in an affidavit or application for an assault weapon endorsement, assault weapon attachment endorsement,

.50 caliber rifle endorsement, or .50 caliber cartridge endorsement under the Firearm Owners Identification Card Act.

(iii) Data exempt from disclosure under Section 50 of the School Safety Drill Act.

(jjj) Information exempt from disclosure under Section 30 of the Insurance Data Security Law.

(kkk) Confidential business information prohibited from disclosure under Section 45 of the Paint Stewardship Act.

(lll) Data exempt from disclosure under Section 2-3.196 of the School Code.

(mmm) Information prohibited from being disclosed under subsection (e) of Section 1-129 of the Illinois Power Agency Act.

(nnn) Materials received by the Department of Commerce and Economic Opportunity that are confidential under the Music and Musicians Tax Credit and Jobs Act.

(ooo) Data or information provided pursuant to Section 20 of the Statewide Recycling Needs and Assessment Act.

(ppp) Information that is exempt from disclosure under Section 28-11 of the Lawful Health Care Activity Act.

(qqq) Information that is exempt from disclosure under Section 7-101 of the Illinois Human Rights Act.

(rrr) Information prohibited from being disclosed under Section 4-2 of the Uniform Money Transmission

Modernization Act.

(sss) Information exempt from disclosure under Section 40 of the Student-Athlete Endorsement Rights Act.

(ttt) Audio recordings made under Section 30 of the Illinois State Police Act, except to the extent authorized under that Section.

(uuu) Information prohibited from being disclosed under Section 30-5 of the Digital Assets Regulation Act.

(www) Annual summary financial and utilization data reports submitted to the Health Facilities and Services Review Board under Section 13 of the Illinois Health Facilities Planning Act.

(Source: P.A. 103-8, eff. 6-7-23; 103-34, eff. 6-9-23; 103-142, eff. 1-1-24; 103-372, eff. 1-1-24; 103-472, eff. 8-1-24; 103-508, eff. 8-4-23; 103-580, eff. 12-8-23; 103-592, eff. 6-7-24; 103-605, eff. 7-1-24; 103-636, eff. 7-1-24; 103-724, eff. 1-1-25; 103-786, eff. 8-7-24; 103-859, eff. 8-9-24; 103-991, eff. 8-9-24; 103-1049, eff. 8-9-24; 103-1081, eff. 3-21-25; 104-10, eff. 6-16-25; 104-18, eff. 6-30-25; 104-417, eff. 8-15-25; 104-428, eff. 8-18-25; 104-457, eff. 6-1-26; revised 1-7-26.)

(Text of Section after amendment by P.A. 104-441)

Sec. 7.5. Statutory exemptions. To the extent provided for by the statutes referenced below, the following shall be exempt from inspection and copying:

(a) All information determined to be confidential under Section 4002 of the Technology Advancement and Development Act.

(b) Library circulation and order records identifying library users with specific materials under the Library Records Confidentiality Act.

(c) Applications, related documents, and medical records received by the Experimental Organ Transplantation Procedures Board and any and all documents or other records prepared by the Experimental Organ Transplantation Procedures Board or its staff relating to applications it has received.

(d) Information and records held by the Department of Public Health and its authorized representatives relating to known or suspected cases of sexually transmitted infection or any information the disclosure of which is restricted under the Illinois Sexually Transmitted Infection Control Act.

(e) Information the disclosure of which is exempted under Section 30 of the Radon Industry Licensing Act.

(f) Firm performance evaluations under Section 55 of the Architectural, Engineering, and Land Surveying Qualifications Based Selection Act.

(g) Information the disclosure of which is restricted and exempted under Section 50 of the Illinois Prepaid Tuition Act.

(h) Information the disclosure of which is exempted under the State Officials and Employees Ethics Act, and records of any lawfully created State or local inspector general's office that would be exempt if created or obtained by an Executive Inspector General's office under that Act.

(i) Information contained in a local emergency energy plan submitted to a municipality in accordance with a local emergency energy plan ordinance that is adopted under Section 11-21.5-5 of the Illinois Municipal Code.

(j) Information and data concerning the distribution of surcharge moneys collected and remitted by carriers under the Emergency Telephone System Act.

(k) Law enforcement officer identification information or driver identification information compiled by a law enforcement agency or the Department of Transportation under Section 11-212 of the Illinois Vehicle Code.

(l) Records and information provided to a residential health care facility resident sexual assault and death review team or the Executive Council under the Abuse Prevention Review Team Act.

(m) Information provided to the predatory lending database created pursuant to Article 3 of the Residential Real Property Disclosure Act, except to the extent authorized under that Article.

(n) Defense budgets and petitions for certification of

compensation and expenses for court appointed trial counsel as provided under Sections 10 and 15 of the Capital Crimes Litigation Act (repealed). This subsection (n) shall apply until the conclusion of the trial of the case, even if the prosecution chooses not to pursue the death penalty prior to trial or sentencing.

(o) Information that is prohibited from being disclosed under Section 4 of the Illinois Health and Hazardous Substances Registry Act.

(p) Security portions of system safety program plans, investigation reports, surveys, schedules, lists, data, or information compiled, collected, or prepared by or for the Department of Transportation under Sections 2705-300 and 2705-616 of the Department of Transportation Law of the Civil Administrative Code of Illinois, the Northern Illinois Transit Authority under Section 2.11 of the Northern Illinois Transit Authority Act, or the St. Clair County Transit District under the Bi-State Transit Safety Act (repealed).

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(y) Confidential information under the Adult Protective Services Act and its predecessor enabling statute, the Elder Abuse and Neglect Act, including information about the identity and administrative finding

against any caregiver of a verified and substantiated decision of abuse, neglect, or financial exploitation of an eligible adult maintained in the Registry established under Section 7.5 of the Adult Protective Services Act.

(z) Records and information provided to a fatality review team or the Illinois Fatality Review Team Advisory Council under Section 15 of the Adult Protective Services Act.

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(ee) Information that is exempted from disclosure under Section 30.1 of the Pharmacy Practice Act.

(ff) Information that is exempted from disclosure under the Revised Uniform Unclaimed Property Act.

(gg) Information that is prohibited from being disclosed under Section 7-603.5 of the Illinois Vehicle Code.

(hh) Records that are exempt from disclosure under

Section 1A-16.7 of the Election Code.

(ii) Information which is exempted from disclosure under Section 2505-800 of the Department of Revenue Law of the Civil Administrative Code of Illinois.

(jj) Information and reports that are required to be submitted to the Department of Labor by registering day and temporary labor service agencies but are exempt from disclosure under subsection (a-1) of Section 45 of the Day and Temporary Labor Services Act.

(kk) Information prohibited from disclosure under the Seizure and Forfeiture Reporting Act.

(ll) Information the disclosure of which is restricted and exempted under Section 5-30.8 of the Illinois Public Aid Code.

(mm) Records that are exempt from disclosure under Section 4.2 of the Crime Victims Compensation Act.

(nn) Information that is exempt from disclosure under Section 70 of the Higher Education Student Assistance Act.

(oo) Communications, notes, records, and reports arising out of a peer support counseling session prohibited from disclosure under the First Responders Suicide Prevention Act.

(pp) Names and all identifying information relating to an employee of an emergency services provider or law enforcement agency under the First Responders Suicide Prevention Act.

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(rr) Information that is exempt from disclosure under the Cannabis Regulation and Tax Act.

(ss) Data reported by an employer to the Department of Human Rights pursuant to Section 2-108 of the Illinois Human Rights Act.

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(uu) Information that is exempt from disclosure under Section 50 of the Sexual Assault Evidence Submission Act.

(vv) Information that is exempt from disclosure under subsections (f) and (j) of Section 5-36 of the Illinois Public Aid Code.

(ww) Information that is exempt from disclosure under Section 16.8 of the State Treasurer Act.

(xx) Information that is exempt from disclosure or information that shall not be made public under the Illinois Insurance Code.

(yy) Information prohibited from being disclosed under the Illinois Educational Labor Relations Act.

(zz) Information prohibited from being disclosed under the Illinois Public Labor Relations Act.

(aaa) Information prohibited from being disclosed

under Section 1-167 of the Illinois Pension Code.

(bbb) Information that is prohibited from disclosure by the Illinois Police Training Act and the Illinois State Police Act.

(ccc) Records exempt from disclosure under Section 2605-304 of the Illinois State Police Law of the Civil Administrative Code of Illinois.

(ddd) Information prohibited from being disclosed under Section 35 of the Address Confidentiality for Victims of Domestic Violence, Sexual Assault, Human Trafficking, or Stalking Act.

(eee) Information prohibited from being disclosed under subsection (b) of Section 75 of the Domestic Violence Fatality Review Act.

(fff) Images from cameras under the Expressway Camera Act and all automated license plate reader (ALPR) information used and collected by the Illinois State Police. "ALPR information" means information gathered by an ALPR or created from the analysis of data generated by an ALPR. This subsection (fff) is inoperative on and after July 1, 2028.

(ggg) Information prohibited from disclosure under paragraph (3) of subsection (a) of Section 14 of the Nurse Agency Licensing Act.

(hhh) Information submitted to the Illinois State Police in an affidavit or application for an assault

weapon endorsement, assault weapon attachment endorsement, .50 caliber rifle endorsement, or .50 caliber cartridge endorsement under the Firearm Owners Identification Card Act.

(iii) Data exempt from disclosure under Section 50 of the School Safety Drill Act.

(jjj) Information exempt from disclosure under Section 30 of the Insurance Data Security Law.

(kkk) Confidential business information prohibited from disclosure under Section 45 of the Paint Stewardship Act.

(lll) Data exempt from disclosure under Section 2-3.196 of the School Code.

(mmm) Information prohibited from being disclosed under subsection (e) of Section 1-129 of the Illinois Power Agency Act.

(nnn) Materials received by the Department of Commerce and Economic Opportunity that are confidential under the Music and Musicians Tax Credit and Jobs Act.

(ooo) Data or information provided pursuant to Section 20 of the Statewide Recycling Needs and Assessment Act.

(ppp) Information that is exempt from disclosure under Section 28-11 of the Lawful Health Care Activity Act.

(qqq) Information that is exempt from disclosure under Section 7-101 of the Illinois Human Rights Act.

(rrr) Information prohibited from being disclosed

under Section 4-2 of the Uniform Money Transmission Modernization Act.

(sss) Information exempt from disclosure under Section 40 of the Student-Athlete Endorsement Rights Act.

(ttt) Audio recordings made under Section 30 of the Illinois State Police Act, except to the extent authorized under that Section.

(uuu) Information prohibited from being disclosed under Section 30-5 of the Digital Assets Regulation Act.

(vvv) ~~(uuu)~~ Information exempt from disclosure under Section 70 of the End-of-Life Options for Terminally Ill Patients Act.

(www) Annual summary financial and utilization data reports submitted to the Health Facilities and Services Review Board under Section 13 of the Illinois Health Facilities Planning Act.

(Source: P.A. 103-8, eff. 6-7-23; 103-34, eff. 6-9-23; 103-142, eff. 1-1-24; 103-372, eff. 1-1-24; 103-472, eff. 8-1-24; 103-508, eff. 8-4-23; 103-580, eff. 12-8-23; 103-592, eff. 6-7-24; 103-605, eff. 7-1-24; 103-636, eff. 7-1-24; 103-724, eff. 1-1-25; 103-786, eff. 8-7-24; 103-859, eff. 8-9-24; 103-991, eff. 8-9-24; 103-1049, eff. 8-9-24; 103-1081, eff. 3-21-25; 104-10, eff. 6-16-25; 104-18, eff. 6-30-25; 104-417, eff. 8-15-25; 104-428, eff. 8-18-25; 104-441, eff. 9-12-26; 104-457, eff. 6-1-26; revised 1-7-26.)

Section 6-75. The Illinois Health Facilities Planning Act is amended by changing Sections 2 and 13 as follows:

(20 ILCS 3960/2) (from Ch. 111 1/2, par. 1152)

(Section scheduled to be repealed on December 31, 2029)

Sec. 2. Purpose of the Act. This Act shall establish a procedure (1) which requires a person establishing, constructing or modifying a health care facility, as herein defined, to have the qualifications, background, character and financial resources to adequately provide a proper service for the community; (2) that promotes the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of such facilities; and (3) that promotes planning for and development of health care facilities needed for comprehensive health care especially in areas where the health planning process has identified unmet needs.

The changes made to this Act by this amendatory Act of the 96th General Assembly are intended to accomplish the following objectives: to improve the financial ability of the public to obtain necessary health services; to establish an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public; to maintain and improve the provision of essential health care services and increase the accessibility of those services to the medically underserved and indigent; to assure that the

reduction and closure of health care services or facilities is performed in an orderly and timely manner, and that these actions are deemed to be in the best interests of the public; and to assess the financial burden to patients caused by unnecessary health care construction and modification. Evidence-based assessments, projections and decisions will be applied regarding capacity, quality, value and equity in the delivery of health care services in Illinois. The integrity of the Certificate of Need process is ensured through revised ethics and communications procedures. Cost containment and support for safety net services must continue to be central tenets of the Certificate of Need process.

The changes made to this Act by this amendatory Act of the 104th General Assembly are intended to allow the State to collect additional information regarding the financial ability for health care facilities to deliver services in Illinois.

(Source: P.A. 99-527, eff. 1-1-17.)

(20 ILCS 3960/13) (from Ch. 111 1/2, par. 1163)

(Section scheduled to be repealed on December 31, 2029)

Sec. 13. Investigation of applications for permits.

(a) Investigations. The State Board shall make or cause to be made such investigations as it deems necessary in connection with an application for a permit, or in connection with a determination of whether or not construction or modification that has been commenced is in accord with the

permit issued by the State Board, or whether construction or modification has been commenced without a permit having been obtained. The State Board may issue subpoenas duces tecum requiring the production of records and may administer oaths to such witnesses.

Any circuit court of this State, upon the application of the State Board or upon the application of any party to such proceedings, may, in its discretion, compel the attendance of witnesses, the production of books, papers, records, or memoranda and the giving of testimony before the State Board, by a proceeding as for contempt, or otherwise, in the same manner as production of evidence may be compelled before the court.

(b) Reports from health facilities. The State Board shall require all health facilities operating in this State to provide such reasonable reports at such times and containing such information as is needed by it to carry out the purposes and provisions of this Act. Prior to collecting information from health facilities, the State Board shall make reasonable efforts through a public process to consult with health facilities and associations that represent them to determine whether data and information requests will result in useful information for health planning, whether sufficient information is available from other sources, and whether data requested is routinely collected by health facilities and is available without retrospective record review. Data and

information requests shall not impose undue paperwork burdens on health care facilities and personnel. Health facilities not complying with this requirement shall be reported to licensing, accrediting, certifying, or payment agencies as being in violation of State law. Health care facilities and other parties at interest shall have reasonable access, under rules established by the State Board, to all planning information submitted in accord with this Act pertaining to their area.

(1) Questionnaires. Among the reports to be required by the State Board are facility questionnaires for health care facilities licensed under the Ambulatory Surgical Treatment Center Act, the Hospital Licensing Act, the Nursing Home Care Act, the ID/DD Community Care Act, the MC/DD Act, or the Specialized Mental Health Rehabilitation Act of 2013 and health care facilities that are required to meet the requirements of 42 CFR 494 in order to be certified for participation in Medicare and Medicaid under Titles XVIII and XIX of the federal Social Security Act. These questionnaires shall be conducted on an annual basis and compiled by the State Board. For health care facilities licensed under the Nursing Home Care Act or the Specialized Mental Health Rehabilitation Act of 2013, these reports shall include, but not be limited to, the identification of specialty services provided by the facility to patients, residents, and the community at

large. Annual reports for facilities licensed under the ID/DD Community Care Act and facilities licensed under the MC/DD Act shall be different from the annual reports required of other health care facilities and shall be specific to those facilities licensed under the ID/DD Community Care Act or the MC/DD Act. The Health Facilities and Services Review Board shall consult with associations representing facilities licensed under the ID/DD Community Care Act and associations representing facilities licensed under the MC/DD Act when developing the information requested in these annual reports. For health care facilities that contain long term care beds, the reports shall also include the number of staffed long term care beds, physical capacity for long term care beds at the facility, and long term care beds available for immediate occupancy. For purposes of this paragraph, "long term care beds" means beds (i) licensed under the Nursing Home Care Act, (ii) licensed under the ID/DD Community Care Act, (iii) licensed under the MC/DD Act, (iv) licensed under the Hospital Licensing Act, or (v) licensed under the Specialized Mental Health Rehabilitation Act of 2013 and certified as skilled nursing or nursing facility beds under Medicaid or Medicare.

For health care facilities licensed under the Hospital Licensing Act, the health care facilities operating in this State shall report the following financial and

utilization data annually: (i) the most recent audited financial statements; (ii) the most recent month-end balance sheet detailing the assets, liabilities, and net worth at the end of the month immediately preceding the annual reporting cycle; (iii) the most recent income statement for the month immediately preceding the annual reporting cycle summarizing the revenues, expenses, and net income; (iv) the total number of inpatient days, outpatient visits, and discharges by payer, including, but not limited to, Medicare, Medicaid fee-for-service, Medicaid managed care, commercial coverage, and other payers; (v) the total inpatient gross revenues by payer, including, but not limited to, Medicare, Medicaid fee-for-service, Medicaid managed care, commercial coverage, and other payers; and (vi) the total outpatient gross revenues by payer, including, but not limited to, Medicare, Medicaid fee-for-service, Medicaid managed care, commercial coverage, and other payers. The transmission of the financial and utilization data shall be due to the State Board within 90 days after the effective date of this amendatory Act of the 104th General Assembly, and thereafter, the data shall be due annually on the regular schedule set by the State Board for questionnaires. The State Board, in coordination with the Department of Healthcare and Family Services and the Department of Public Health, shall administer the collection of the

financial and utilization data submitted under this Section. The State Board may adopt any administrative rules, including emergency rules, necessary to implement this Section, including requesting additional information or removing information from the reporting requirements. If a health care facility has not filed the required financial and utilization data within 90 days after the close of the annual reporting period, the State Board shall impose fines of not more than $5,000 per week for failure to comply with the provisions of this Section.

(2) Confidentiality.

(A) The State Board shall keep confidential the annual summary financial and utilization data report submitted under this Section and all information in the report as required by this Section. The financial and utilization data shall remain confidential, is not subject to subpoena, is not subject to discovery or admissible as evidence in private civil litigation, is not subject to disclosure under the Freedom of Information Act, and must not be made public at any time or used by the State Board or any other person, except as provided in subparagraphs (B), (D), and (E) of this paragraph (2).

(B) Notwithstanding subparagraph (A), the State Board may:

(i) share the financial and utilization data

submitted under this Section with other State agencies;

(ii) share the financial and utilization data submitted under this Section with third-party vendors or contractors of a State agency, federal regulatory agencies, or law enforcement authorities, if the recipient agrees to and verifies in writing its legal authority to maintain the confidentiality and privileged status of the financial and utilization data;

(iii) enter into agreements governing the sharing and use of information consistent with this Section.

(C) Disclosure of the financial and utilization data to the State Board and by the State Board under this Section does not waive any applicable privilege or claim of confidentiality in the report or information.

(D) Notwithstanding the confidentiality requirements of this Section or otherwise imposed by State law, relevant State agencies may make public financial and utilization data submitted under this Section in an aggregated format that does not disclose information or data attributed to any specific facility.

(E) Notwithstanding the confidentiality

requirements of this Section, a State agency may disclose the financial and utilization data submitted under this Section with the written consent of the hospital that submitted the report.

(Source: P.A. 100-681, eff. 8-3-18; 100-957, eff. 8-19-18; 101-81, eff. 7-12-19.)

Section 6-80. The Hospital Licensing Act is amended by adding Section 4.8 as follows:

(210 ILCS 85/4.8 new)

Sec. 4.8. Additional licensing requirements.

(a) Hospital emergency and financial contingency plan. Any hospital licensed under this Act that has outstanding debts to the State in the form of tax arrears or that maintains debt through the Distressed Hospital Loan Program or other Medicaid advance payments shall submit to the Department a hospital emergency and financial contingency plan for the rapid and orderly resolution of finances and operations in the event of material financial distress. The plan shall be submitted on an annual basis until any outstanding assessment or advance balances have been fully paid. The plan shall include, but not be limited to, procedures for the safe and orderly transfer and continuity of care for patients if closure of at least one category of service, or a temporary suspension of such service for any reason, were to occur. Potential events precipitating

closure or suspended services that shall be addressed in the plan, include, but are not limited to: financial distress, regulatory and compliance issues, operational or workforce challenges, infrastructure and facility issues, emergency or disaster related causes, and strategic organizational decisions. The plan shall contemplate (i) the identification of potential service area gaps created due to emergency closure and suspension of services and (ii) the orderly preservation and transfer of medical records in accordance with the Medical Patient Rights Act, the Health Insurance Portability and Accountability Act of 1996, and other applicable medical privacy laws.

(b) Hospital emergency and financial contingency plans for hospitals with multiple locations operating under a single license. Any hospital licensed by the Department under Section 4.5 of this Act and required to submit a hospital emergency and financial contingency plan shall submit a hospital emergency and financial contingency plan as outlined in subsection (a) considering each location, campus, or facility administered under the license that could reasonably be affected.

(c) Annual filing. Hospital emergency and financial contingency plans shall be filed with the Department no later than 3 months after the effective date of this amendatory Act of the 104th General Assembly. Hospital emergency and financial contingency plans, or annual affirmations of previously filed hospital emergency and financial contingency

plans, as outlined in this Section shall be submitted on an annual basis as determined by the Department through administrative rule.

(d) Penalties for noncompliance. The Department may impose fines of not more than $500 per week for failure to comply with the provisions of this Section.

(e) This Section is operative on and after January 1, 2027.

ARTICLE 10.

Section 10-5. The Rebuild Illinois Mental Health Workforce Act is amended by changing Section 20-10 as follows:

(305 ILCS 66/20-10)

Sec. 20-10. Medicaid funding for community mental health services. Medicaid funding for the specific community mental health services listed in this Act shall be adjusted and paid as set forth in this Act. Such payments shall be paid in addition to the base Medicaid reimbursement rate and add-on payment rates per service unit.

(a) The following payment adjustments shall begin on July 1, 2022 for State Fiscal Year 2023 and shall continue for every State fiscal year thereafter.

(1) Individual Therapy Medicaid Payment rate for services provided under the H0004 Code:

(A) The Medicaid total payment rate for individual therapy provided by a qualified mental health professional shall be increased by no less than $9 per service unit.

(B) The Medicaid total payment rate for individual therapy provided by a mental health professional shall be increased by no less than $9 per service unit.

(2) Community Support - Individual Medicaid Payment rate for services provided under the H2015 Code: All community support - individual services shall be increased by no less than $15 per service unit.

(3) Case Management Medicaid Add-on Payment for services provided under the T1016 code: All case management services rates shall be increased by no less than $15 per service unit.

(4) Assertive Community Treatment Medicaid Add-on Payment for services provided under the H0039 code: The Medicaid total payment rate for assertive community treatment services shall increase by no less than $8 per service unit.

(b) ~~(5)~~ Medicaid user-based directed payments. The following directed payments shall be paid to qualifying providers for State Fiscal Year 2023 through State Fiscal Year 2026. This subsection does not prevent the Department from making payments in future State fiscal years to correct errors or omissions made in State Fiscal Year 2023 through State

Fiscal Year 2026 payments.

(1) ~~(A)~~ For each State fiscal year, a monthly directed payment shall be paid to a community mental health provider of community support team services based on the number of Medicaid users of community support team services documented by Medicaid fee-for-service and managed care encounter claims delivered by that provider in the base year. The Department of Healthcare and Family Services shall make the monthly directed payment to each provider entitled to directed payments under this Act by no later than the last day of each month throughout each State fiscal year.

(A) ~~(i)~~ The monthly directed payment for a community support team provider shall be calculated as follows: The sum total number of individual Medicaid users of community support team services delivered by that provider throughout the base year, multiplied by $4,200 per Medicaid user, divided into 12 equal monthly payments for the State fiscal year.

(B) ~~(ii)~~ As used in this subparagraph, "user" means an individual who received at least 200 units of community support team services (H2016) during the base year.

(2) ~~(B)~~ For each State fiscal year, a monthly directed payment shall be paid to each community mental health provider of assertive community treatment services based

on the number of Medicaid users of assertive community treatment services documented by Medicaid fee-for-service and managed care encounter claims delivered by the provider in the base year.

(A) ~~(i)~~ The monthly direct payment for an assertive community treatment provider shall be calculated as follows: The sum total number of Medicaid users of assertive community treatment services provided by that provider throughout the base year, multiplied by $6,000 per Medicaid user, divided into 12 equal monthly payments for that State fiscal year.

(B) ~~(ii)~~ As used in this subparagraph, "user" means an individual that received at least 300 units of assertive community treatment services during the base year.

(3) ~~(C)~~ The base year for directed payments under this Section shall be calendar year 2019 for State Fiscal Year 2023 and State Fiscal Year 2024. For the State fiscal year beginning on July 1, 2024, and for every State fiscal year thereafter, the base year shall be the calendar year that ended 18 months prior to the start of the State fiscal year in which payments are made.

(b-5) ~~(b)~~ Subject to federal approval, a one-time directed payment must be made in calendar year 2023 for community mental health services provided by community mental health

providers. The one-time directed payment shall be for an amount appropriated for these purposes. The one-time directed payment shall be for services for Integrated Assessment and Treatment Planning and other intensive services, including, but not limited to, services for Mobile Crisis Response, crisis intervention, and medication monitoring. The amounts and services used for designing and distributing these one-time directed payments shall not be construed to require any future rate or funding increases for the same or other mental health services.

(b-6) Subject to federal approval, for dates of service on and after July 1, 2026, the Medicaid reimbursement rates for Assertive Community Treatment and Community Support Team services shall be increased by an amount no less than the following targeted pools. The Department must use service units delivered under the fee-for-service and managed care programs by community mental health centers during State Fiscal Year 2024 for distributing the targeted pools and setting rates.

(1) Assertive Community Treatment, $10,600,000; and

(2) Community Support Team services, $17,500,000.

(c) The following payment adjustments shall be made:

(1) Subject to federal approval, beginning on January 1, 2024, the Department shall introduce rate increases to behavioral health services no less than by the following targeted pool for the specified services provided by

community mental health centers:

(A) Mobile Crisis Response, $6,800,000;

(B) Crisis Intervention, $4,000,000;

(C) Integrative Assessment and Treatment Planning services, $10,500,000;

(D) Group Therapy, $1,200,000;

(E) Family Therapy, $500,000;

(F) Community Support Group, $4,000,000; and

(G) Medication Monitoring, $3,000,000.

(2) Rate increases shall be determined with significant input from Illinois behavioral health trade associations and advocates. The Department must use service units delivered under the fee-for-service and managed care programs by community mental health centers during State Fiscal Year 2022. These services are used for distributing the targeted pools and setting rates but do not prohibit the Department from paying providers not enrolled as community mental health centers the same rate if providing the same services.

(d) Rate simplification for team-based services.

(1) The Department shall work with stakeholders to redesign reimbursement rates for behavioral health team-based services established under the Rehabilitation Option of the Illinois Medicaid State Plan supporting individuals with chronic or complex behavioral health conditions and crisis services. Subject to federal

approval, the redesigned rates shall seek to introduce bundled payment systems that minimize provider claiming activities while transitioning the focus of treatment towards metrics and outcomes. Federally approved rate models shall seek to ensure reimbursement levels are no less than the State's total reimbursement for similar services in calendar year 2023, including all service level payments, add-ons, and all other payments specified in this Section.

(2) In State Fiscal Year 2024, the Department shall identify an existing, or establish a new, Behavioral Health Outcomes Stakeholder Workgroup to help inform the identification of metrics and outcomes for team-based services.

(3) In State Fiscal Year 2025, subject to federal approval, the Department shall introduce a pay-for-performance model for team-based services to be informed by the Behavioral Health Outcomes Stakeholder Workgroup.

(Source: P.A. 102-699, eff. 4-19-22; 102-1118, eff. 1-18-23; 103-102, eff. 7-1-23; 103-154, eff. 6-30-23.)

ARTICLE 15.

Section 15-5. The State Finance Act is amended by changing Section 5.945 as follows:

(30 ILCS 105/5.945)

Sec. 5.945. The Medicaid Technical Assistance Center Fund. Notwithstanding any other provision of law, in addition to any other transfers that may be provided by law, on July 1, 2026, or as soon thereafter as practical, the State Comptroller shall direct and the State Treasurer shall transfer the remaining balance from the Medicaid Technical Assistance Center Fund into the Healthcare Provider Relief Fund. Upon completion of the transfers, the Medicaid Technical Assistance Center Fund is dissolved, and any future deposits due to that Fund and any outstanding obligations or liabilities of that Fund pass to the Healthcare Provider Relief Fund.

(Source: P.A. 102-4, Article 185, Section 185-90, eff. 4-27-21; 102-813, eff. 5-13-22.)

Section 15-10. The Medicaid Technical Assistance Act is amended by changing Sections 185-5 and 185-15 as follows:

(305 ILCS 75/185-5)

Sec. 185-5. Definitions. As used in this Act:

"Behavioral health providers" includes providers of mental health, substance use disorder, developmental disabilities, and autism services for purposes of this Act, but does not change any other legal, programmatic, diagnostic, or clinical provisions defining or relating to coverage of such services.

~~means mental health and substance use disorder providers.~~

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

"Health care providers" means individuals and organizations that ~~who~~ provide physical, mental, or substance use disorder services, or services supporting social determinants ~~determinant~~ of health ~~services~~.

"Health equity" means providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

~~"Network adequacy" means a Medicaid beneficiaries' ability to access all necessary provider types within time and distance standards as defined in the Managed Care Organization model contract.~~

"Service deserts" means geographic areas of the State with no or limited Medicaid providers that accept Medicaid.

"Social determinants of health" means any conditions that impact an individual's health, including, but not limited to, access to healthy food, safety, education, and housing stability.

"Stakeholders" means, but are not limited to, health care providers, advocacy organizations, managed care organizations, Medicaid beneficiaries, and State and city partners.

(Source: P.A. 102-4, eff. 4-27-21.)

(305 ILCS 75/185-15)

Sec. 185-15. Collaboration. The Medicaid Technical Assistance Center shall collaborate with public and private partners throughout the State to identify, establish, and maintain best practices necessary for health providers to ensure their capacity to participate in the Illinois Medical Assistance Program. The Medicaid Technical Assistance Center shall promote equitable delivery systems, remaining committed to the principle that all Medicaid recipients have accessible and equitable physical and mental health care services ~~HealthChoice Illinois or YouthCare~~. The Medicaid Technical Assistance Center shall administer the following:

(1) Outreach and engagement: The Medicaid Technical Assistance Center shall undertake efforts to identify and engage community-based providers offering services to customers funded by the Department, including, but not limited to, behavioral health services and ~~or~~ services addressing the social determinants of health, especially those predominantly serving communities of color or those operating within or near service deserts, for the purpose of offering training and technical assistance to them through the Medicaid Technical Assistance Center. Outreach and engagement services may be subcontracted.

(2) Trainings: The Medicaid Technical Assistance Center shall create and administer ongoing trainings for health care providers. Trainings may be subcontracted. The Medicaid Technical Assistance Center shall provide

in-person and web-based trainings. In-person training shall be conducted throughout the State. All trainings must be free of charge. The Medicaid Technical Assistance Center shall administer post-training surveys and incorporate feedback. Training content and delivery must be reflective of Illinois providers' varying levels of readiness, resources, and client populations.

(3) Web-based resources: The Medicaid Technical Assistance Center shall maintain an independent, easy to navigate, and up-to-date website that includes, but is not limited to: recorded training archives, a training calendar, provider resources and tools, up-to-date explanations of Department and managed care organization guidance, a running database of frequently asked questions and contact information for key staff members of the Department, managed care organizations, and the Medicaid Technical Assistance Center.

(4) Learning collaboratives: The Medicaid Technical Assistance Center shall host regional learning collaboratives that will supplement the Medicaid Technical Assistance Center training curriculum to bring together groups of stakeholders to share issues and best practices, and to escalate issues. Leadership of the Department and managed care organizations shall attend learning collaboratives on a quarterly basis.

(5) Network <u>recruitment plan: Using reports and data</u>

provided by the Department's External Quality Review Organization on ~~adequacy reports: The Medicaid Technical Assistance Center shall publicly release a report on Medicaid provider~~ network adequacy, ~~within the first 3 years of implementation and annually thereafter. The reports shall identify~~ provider service deserts, and health care disparities by race and ethnicity, the Medicaid Technical Assistance Center shall propose for Department review and approval an annual plan for recruiting providers to participate in the Illinois Medical Assistance Program and report on outcomes of its recruitment efforts to the Department for continuous improvement. Recruitment plans shall prioritize efforts to bolster access in provider service deserts and in communities experiencing health care disparities by race and ethnicity, with a special focus on behavioral health services and services that address social determinants of health.

(6) Equitable delivery system: The Medicaid Technical Assistance Center is committed to the principle that all Medicaid recipients have accessible and equitable physical and mental health care services. All providers served through the Medicaid Technical Assistance Center shall deliver services notwithstanding the patient's race, color, gender, gender identity, age, ancestry, marital status, military status, religion, national origin,

disability status, sexual orientation, order of protection status, as defined under Section 1-103 of the Illinois Human Rights Act, or immigration status.

(Source: P.A. 102-4, eff. 4-27-21.)

(305 ILCS 75/185-20 rep.)

(305 ILCS 75/185-25 rep.)

Section 15-15. The Medicaid Technical Assistance Act is amended by repealing Sections 185-20 and 185-25.

ARTICLE 20.

Section 20-5. The Illinois Public Aid Code is amended by changing Section 5-5f as follows:

(305 ILCS 5/5-5f)

Sec. 5-5f. Elimination and limitations of medical assistance services. Notwithstanding any other provision of this Code to the contrary, on and after July 1, 2012:

(a) The following service shall no longer be a covered service available under this Code: group psychotherapy for residents of any facility licensed under the Nursing Home Care Act or the Specialized Mental Health Rehabilitation Act of 2013.

(b) The Department shall place the following limitations on services: (i) the Department shall limit

adult eyeglasses to one pair every 2 years; however, the limitation does not apply to an individual who needs different eyeglasses following a surgical procedure such as cataract surgery; (ii) the Department shall set an annual limit of a maximum of 20 visits for each of the following services: adult speech, hearing, and language therapy services, adult occupational therapy services, and physical therapy services; on or after October 1, 2014, the annual maximum limit of 20 visits shall expire but the Department may require prior approval for all individuals for speech, hearing, and language therapy services, occupational therapy services, and physical therapy services; (iii) the Department shall limit adult podiatry services to individuals with diabetes; on or after October 1, 2014, podiatry services shall not be limited to individuals with diabetes; (iv) the Department shall pay for caesarean sections at the normal vaginal delivery rate unless a caesarean section was medically necessary; (v) the Department shall limit adult dental services to emergencies; beginning July 1, 2013, the Department shall ensure that the following conditions are recognized as emergencies: (A) dental services necessary for an individual in order for the individual to be cleared for a medical procedure, such as a transplant; (B) extractions and dentures necessary for a diabetic to receive proper nutrition; (C) extractions and dentures necessary as a

result of cancer treatment; and (D) dental services necessary for the health of a pregnant woman prior to delivery of her baby; on or after July 1, 2014, adult dental services shall no longer be limited to emergencies, and dental services necessary for the health of a pregnant woman prior to delivery of her baby shall continue to be covered; and (vi) effective July 1, 2012 through June 30, 2021, the Department shall place limitations and require concurrent review on every inpatient detoxification stay to prevent repeat admissions to any hospital for detoxification within 60 days of a previous inpatient detoxification stay. The Department shall convene a workgroup of hospitals, substance abuse providers, care coordination entities, managed care plans, and other stakeholders to develop recommendations for quality standards, diversion to other settings, and admission criteria for patients who need inpatient detoxification, which shall be published on the Department's website no later than September 1, 2013.

(c) The Department shall require prior approval of the following services: wheelchair repairs costing more than $750, coronary artery bypass graft, and bariatric surgery consistent with Medicare standards concerning patient responsibility. Wheelchair repair prior approval requests shall be adjudicated within one business day of receipt of complete supporting documentation. Providers may not break

wheelchair repairs into separate claims for purposes of staying under the $750 threshold for requiring prior approval. The wholesale price of manual and power wheelchairs, durable medical equipment and supplies, and complex rehabilitation technology products and services shall be defined as actual acquisition cost including all discounts.

(d) (Blank). ~~The Department shall establish benchmarks for hospitals to measure and align payments to reduce potentially preventable hospital readmissions, inpatient complications, and unnecessary emergency room visits. In doing so, the Department shall consider items, including, but not limited to, historic and current acuity of care and historic and current trends in readmission. The Department shall publish provider-specific historical readmission data and anticipated potentially preventable targets 60 days prior to the start of the program. In the instance of readmissions, the Department shall adopt policies and rates of reimbursement for services and other payments provided under this Code to ensure that, by June 30, 2013, expenditures to hospitals are reduced by, at a minimum, $40,000,000.~~

(e) The Department shall establish utilization controls for the hospice program such that it shall not pay for other care services when an individual is in hospice.

(f) For home health services, the Department shall require Medicare certification of providers participating in the program and implement the Medicare face-to-face encounter rule. The Department shall require providers to implement auditable electronic service verification based on global positioning systems or other cost-effective technology.

(g) For the Home Services Program operated by the Department of Human Services and the Community Care Program operated by the Department on Aging, the Department of Human Services, in cooperation with the Department on Aging, shall implement an electronic service verification based on global positioning systems or other cost-effective technology.

(h) Effective with inpatient hospital admissions on or after July 1, 2012, the Department shall reduce the payment for a claim that indicates the occurrence of a provider-preventable condition during the admission as specified by the Department in rules. The Department shall not pay for services related to an other provider-preventable condition.

As used in this subsection (h):

"Provider-preventable condition" means a health care acquired condition as defined under the federal Medicaid regulation found at 42 CFR 447.26 or an other provider-preventable condition.

"Other provider-preventable condition" means a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.

(i) The Department shall implement cost savings initiatives for advanced imaging services, cardiac imaging services, pain management services, and back surgery. Such initiatives shall be designed to achieve annual costs savings.

(j) The Department shall ensure that beneficiaries with a diagnosis of epilepsy or seizure disorder in Department records will not require prior approval for anticonvulsants.

(Source: P.A. 101-209, eff. 8-5-19; 102-43, Article 5, Section 5-5, eff. 7-6-21; 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article 80, Section 80-5, eff. 7-6-21; 102-813, eff. 5-13-22.)

ARTICLE 25.

Section 25-5. The Illinois Public Aid Code is amended by changing Section 14-12 as follows:

(305 ILCS 5/14-12)

Sec. 14-12. Hospital rate reform payment system. The

hospital payment system pursuant to Section 14-11 of this Article shall be as follows:

(a) Inpatient hospital services. Effective on and after the effective date of this amendatory Act of the 104th General Assembly, reimbursement for inpatient general acute care services shall utilize the All Patient Refined Diagnosis Related Grouping (APR-DRG) software distributed by Solventum™ previously known as 3M™ Health Information System. Solventum™ shall be the exclusive provider of this software unless the Department determines that Solventum™ is unable to meet the required operational or contractual terms. Only under these circumstances may an alternative authorized provider of the software be considered.

(1) The Department shall establish Medicaid weighting factors to be used in the reimbursement system established under this subsection. Initial weighting factors shall be the weighting factors as published by the authorized provider of this software adjusted for the Illinois experience.

(2) The Department shall establish a statewide-standardized amount to be used in the inpatient reimbursement system. The Department shall publish these amounts on its website no later than 10 calendar days prior to their effective date.

(3) In addition to the statewide-standardized amount, the Department shall develop adjusters to adjust the rate

of reimbursement for critical Medicaid providers or services for trauma, transplantation services, perinatal care, and Graduate Medical Education (GME).

(4) The Department shall develop add-on payments to account for exceptionally costly inpatient stays, consistent with Medicare outlier principles. Outlier fixed loss thresholds may be updated to control for excessive growth in outlier payments no more frequently than on an annual basis, but at least once every 4 years. Upon updating the fixed loss thresholds, the Department shall be required to update base rates within 12 months.

(5) The Department shall define those hospitals or distinct parts of hospitals that shall be exempt from the APR-DRG reimbursement system established under this Section. The Department shall publish these hospitals' inpatient rates on its website no later than 10 calendar days prior to their effective date.

(6) Beginning July 1, 2014 and ending on December 31, 2023, in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for safety-net hospitals defined in Section 5-5e.1 of this Code excluding pediatric hospitals.

(7) Beginning July 1, 2014, in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for Illinois freestanding inpatient psychiatric hospitals

that are not designated as children's hospitals by the Department but are primarily treating patients under the age of 21.

(7.5) (Blank).

(8) Beginning July 1, 2018, in addition to the statewide-standardized amount, the Department shall adjust the rate of reimbursement for hospitals designated by the Department of Public Health as a Perinatal Level II or II+ center by applying the same adjustor that is applied to Perinatal and Obstetrical care cases for Perinatal Level III centers, as of December 31, 2017.

(9) Beginning July 1, 2018, in addition to the statewide-standardized amount, the Department shall apply the same adjustor that is applied to trauma cases as of December 31, 2017 to inpatient claims to treat patients with burns, including, but not limited to, APR-DRGs 841, 842, 843, and 844.

(10) Beginning July 1, 2018, the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%.

(11) Beginning July 1, 2018, the reimbursement for inpatient rehabilitation services shall be increased by the addition of a $96 per day add-on.

(b) Outpatient hospital services. Effective on and after the effective date of this amendatory Act of the 104th General Assembly, reimbursement for outpatient services shall utilize the Enhanced Ambulatory Procedure Grouping (EAPG) software distributed by Solventum™ previously known as 3M™ Health Information System. Solventum™ shall be the exclusive provider of this software unless the Agency determines that Solventum™ is unable to meet the required operational or contractual terms. Only under these circumstances may an alternative authorized provider of the software be considered.

(1) The Department shall establish Medicaid weighting factors to be used in the reimbursement system established under this subsection. The initial weighting factors shall be the weighting factors as published by the authorized provider.

(2) The Department shall establish service specific statewide-standardized amounts to be used in the reimbursement system.

(A) The initial statewide standardized amounts, with the labor portion adjusted by the Calendar Year 2013 Medicare Outpatient Prospective Payment System wage index with reclassifications, shall be published by the Department on its website no later than 10

calendar days prior to their effective date.

(B) The Department shall establish adjustments to the statewide-standardized amounts for each Critical Access Hospital, as designated by the Department of Public Health in accordance with 42 CFR 485, Subpart F. For outpatient services provided on or before June 30, 2018, the EAPG standardized amounts are determined separately for each critical access hospital such that simulated EAPG payments using outpatient base period paid claim data plus payments under Section 5A-12.4 of this Code net of the associated tax costs are equal to the estimated costs of outpatient base period claims data with a rate year cost inflation factor applied.

(3) In addition to the statewide-standardized amounts, the Department shall develop adjusters to adjust the rate of reimbursement for critical Medicaid hospital outpatient providers or services, including outpatient high volume or safety-net hospitals. Beginning July 1, 2018, the outpatient high volume adjustor shall be increased to increase annual expenditures associated with this adjustor by $79,200,000, based on the State Fiscal Year 2015 base year data and this adjustor shall apply to public hospitals, except for large public hospitals, as defined under 89 Ill. Adm. Code 148.25(a).

(4) Beginning July 1, 2018, in addition to the statewide standardized amounts, the Department shall make

an add-on payment for outpatient expensive devices and drugs. This add-on payment shall at least apply to claim lines that: (i) are assigned with one of the following EAPGs: 490, 1001 to 1020, and coded with one of the following revenue codes: 0274 to 0276, 0278; or (ii) are assigned with one of the following EAPGs: 430 to 441, 443, 444, 460 to 465, 495, 496, 1090. The add-on payment shall be calculated as follows: the claim line's covered charges multiplied by the hospital's total acute cost to charge ratio, less the claim line's EAPG payment plus $1,000, multiplied by 0.8.

(5) Beginning July 1, 2018, the statewide-standardized amounts for outpatient services shall be increased by a uniform percentage so that base claims projected reimbursement is increased by an amount equal to no less than the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of subsection (a) and paragraphs (3) and (4) of this subsection multiplied by 46%.

(6) Effective for dates of service on or after July 1, 2018, the Department shall establish adjustments to the statewide-standardized amounts for each Critical Access Hospital, as designated by the Department of Public Health in accordance with 42 CFR 485, Subpart F, such that each Critical Access Hospital's standardized amount for outpatient services shall be increased by the applicable

uniform percentage determined pursuant to paragraph (5) of this subsection. It is the intent of the General Assembly that the adjustments required under this paragraph (6) by Public Act 100-1181 shall be applied retroactively to claims for dates of service provided on or after July 1, 2018.

(7) Effective for dates of service on or after March 8, 2019 (the effective date of Public Act 100-1181), the Department shall recalculate and implement an updated statewide-standardized amount for outpatient services provided by hospitals that are not Critical Access Hospitals to reflect the applicable uniform percentage determined pursuant to paragraph (5).

(1) Any recalculation to the statewide-standardized amounts for outpatient services provided by hospitals that are not Critical Access Hospitals shall be the amount necessary to achieve the increase in the statewide-standardized amounts for outpatient services increased by a uniform percentage, so that base claims projected reimbursement is increased by an amount equal to no less than the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of subsection (a) and paragraphs (3) and (4) of this subsection, for all hospitals that are not Critical Access Hospitals,

multiplied by 46%.

(2) It is the intent of the General Assembly that the recalculations required under this paragraph (7) by Public Act 100-1181 shall be applied prospectively to claims for dates of service provided on or after March 8, 2019 (the effective date of Public Act 100-1181) and that no recoupment or repayment by the Department or an MCO of payments attributable to recalculation under this paragraph (7), issued to the hospital for dates of service on or after July 1, 2018 and before March 8, 2019 (the effective date of Public Act 100-1181), shall be permitted.

(8) The Department shall ensure that all necessary adjustments to the managed care organization capitation base rates necessitated by the adjustments under subparagraph (6) or (7) of this subsection are completed and applied retroactively in accordance with Section 5-30.8 of this Code within 90 days of March 8, 2019 (the effective date of Public Act 100-1181).

(9) Within 60 days after federal approval of the change made to the assessment in Section 5A-2 by Public Act 101-650, the Department shall incorporate into the EAPG system for outpatient services those services performed by hospitals currently billed through the Non-Institutional Provider billing system.

(b-5) Notwithstanding any other provision of this Section,

beginning with dates of service on and after January 1, 2023, any general acute care hospital with more than 500 outpatient psychiatric Medicaid services to persons under 19 years of age in any calendar year shall be paid the outpatient add-on payment of no less than $113.

(c) In consultation with the hospital community, the Department is authorized to replace 89 Ill. Adm. Code 152.150 as published in 38 Ill. Reg. 4980 through 4986 within 12 months of June 16, 2014 (the effective date of Public Act 98-651). If the Department does not replace these rules within 12 months of June 16, 2014 (the effective date of Public Act 98-651), the rules in effect for 152.150 as published in 38 Ill. Reg. 4980 through 4986 shall remain in effect until modified by rule by the Department. Nothing in this subsection shall be construed to mandate that the Department file a replacement rule.

(d) Transition period. There shall be a transition period to the reimbursement systems authorized under this Section that shall begin on the effective date of these systems and continue until June 30, 2018, unless extended by rule by the Department. To help provide an orderly and predictable transition to the new reimbursement systems and to preserve and enhance access to the hospital services during this transition, the Department shall allocate a transitional hospital access pool of at least $290,000,000 annually so that transitional hospital access payments are made to hospitals.

(1) After the transition period, the Department may

begin incorporating the transitional hospital access pool into the base rate structure; however, the transitional hospital access payments in effect on June 30, 2018 shall continue to be paid, if continued under Section 5A-16.

(2) After the transition period, if the Department reduces payments from the transitional hospital access pool, it shall increase base rates, develop new adjustors, adjust current adjustors, develop new hospital access payments based on updated information, or any combination thereof by an amount equal to the decreases proposed in the transitional hospital access pool payments, ensuring that the entire transitional hospital access pool amount shall continue to be used for hospital payments.

(d-5) Hospital and health care transformation program. The Department shall develop a hospital and health care transformation program to provide financial assistance to hospitals in transforming their services and care models to better align with the needs of the communities they serve. The payments authorized in this Section shall be subject to approval by the federal government.

(1) Phase 1. In State fiscal years 2019 through 2020, the Department shall allocate funds from the transitional access hospital pool to create a hospital transformation pool of at least $262,906,870 annually and make hospital transformation payments to hospitals. Subject to Section 5A-16, in State fiscal years 2019 and 2020, an Illinois

hospital that received either a transitional hospital access payment under subsection (d) or a supplemental payment under subsection (f) of this Section in State fiscal year 2018, shall receive a hospital transformation payment as follows:

(A) If the hospital's Rate Year 2017 Medicaid inpatient utilization rate is equal to or greater than 45%, the hospital transformation payment shall be equal to 100% of the sum of its transitional hospital access payment authorized under subsection (d) and any supplemental payment authorized under subsection (f).

(B) If the hospital's Rate Year 2017 Medicaid inpatient utilization rate is equal to or greater than 25% but less than 45%, the hospital transformation payment shall be equal to 75% of the sum of its transitional hospital access payment authorized under subsection (d) and any supplemental payment authorized under subsection (f).

(C) If the hospital's Rate Year 2017 Medicaid inpatient utilization rate is less than 25%, the hospital transformation payment shall be equal to 50% of the sum of its transitional hospital access payment authorized under subsection (d) and any supplemental payment authorized under subsection (f).

(2) Phase 2.

(A) The funding amount from phase one shall be

incorporated into directed payment and pass-through payment methodologies described in Section 5A-12.7.

(B) Because there are communities in Illinois that experience significant health care disparities due to systemic racism, as recently emphasized by the COVID-19 pandemic, aggravated by social determinants of health and a lack of sufficiently allocated health care resources, particularly community-based services, preventive care, obstetric care, chronic disease management, and specialty care, the Department shall establish a health care transformation program that shall be supported by the transformation funding pool. It is the intention of the General Assembly that innovative partnerships funded by the pool must be designed to establish or improve integrated health care delivery systems that will provide significant access to the Medicaid and uninsured populations in their communities, as well as improve health care equity. It is also the intention of the General Assembly that partnerships recognize and address the disparities revealed by the COVID-19 pandemic, as well as the need for post-COVID care. During State fiscal years 2021 through 2027, the hospital and health care transformation program shall be supported by an annual transformation funding pool of up to $150,000,000, pending federal matching funds, to be allocated during

the specified fiscal years for the purpose of facilitating hospital and health care transformation. Funds that had been budgeted but unexpended in State fiscal years 2021 through 2027 may be allocated in State fiscal year 2028 in an amount not to exceed $150,000,000. No disbursement of moneys for transformation projects from the transformation funding pool described under this Section shall be considered an award, a grant, or an expenditure of grant funds. Funding agreements made in accordance with the transformation program shall be considered purchases of care under the Illinois Procurement Code, and funds shall be expended by the Department in a manner that maximizes federal funding to expend the entire allocated amount.

The Department shall convene, within 30 days after March 12, 2021 (the effective date of Public Act 101-655), a workgroup that includes subject matter experts on health care disparities and stakeholders from distressed communities, which could be a subcommittee of the Medicaid Advisory Committee, to review and provide recommendations on how Department policy, including health care transformation, can improve health disparities and the impact on communities disproportionately affected by COVID-19. The workgroup shall consider and make recommendations

on the following issues: a community safety-net designation of certain hospitals, racial equity, and a regional partnership to bring additional specialty services to communities.

(C) As provided in paragraph (9) of Section 3 of the Illinois Health Facilities Planning Act, any hospital participating in the transformation program may be excluded from the requirements of the Illinois Health Facilities Planning Act for those projects related to the hospital's transformation. To be eligible, the hospital must submit to the Health Facilities and Services Review Board approval from the Department that the project is a part of the hospital's transformation.

(D) As provided in subsection (a-20) of Section 32.5 of the Emergency Medical Services (EMS) Systems Act, a hospital that received hospital transformation payments under this Section may convert to a freestanding emergency center. To be eligible for such a conversion, the hospital must submit to the Department of Public Health approval from the Department that the project is a part of the hospital's transformation.

(E) Criteria for proposals. To be eligible for funding under this Section, a transformation proposal shall meet all of the following criteria:

(i) the proposal shall be designed based on community needs assessment completed by either a University partner or other qualified entity with significant community input;

(ii) the proposal shall be a collaboration among providers across the care and community spectrum, including preventative care, primary care, specialty care, hospital services, mental health and substance abuse services, as well as community-based entities that address the social determinants of health;

(iii) the proposal shall be specifically designed to improve health care outcomes and reduce health care disparities, and improve the coordination, effectiveness, and efficiency of care delivery;

(iv) the proposal shall have specific measurable metrics related to disparities that will be tracked by the Department and made public by the Department;

(v) the proposal shall include a commitment to include Business Enterprise Program certified vendors or other entities controlled and managed by minorities or women; and

(vi) the proposal shall specifically increase access to primary, preventive, or specialty care.

(F) Entities eligible to be funded.

(i) Proposals for funding should come from collaborations operating in one of the most distressed communities in Illinois as determined by the U.S. Centers for Disease Control and Prevention's Social Vulnerability Index for Illinois and areas disproportionately impacted by COVID-19 or from rural areas of Illinois.

(ii) The Department shall prioritize partnerships from distressed communities, which include Business Enterprise Program certified vendors or other entities controlled and managed by minorities or women and also include one or more of the following: safety-net hospitals, critical access hospitals, the campuses of hospitals that have closed since January 1, 2018, or other health care providers designed to address specific health care disparities, including the impact of COVID-19 on individuals and the community and the need for post-COVID care. All funded proposals must include specific measurable goals and metrics related to improved outcomes and reduced disparities which shall be tracked by the Department.

(iii) The Department should target the funding in the following ways: $30,000,000 of

transformation funds to projects that are a collaboration between a safety-net hospital, particularly community safety-net hospitals, and other providers and designed to address specific health care disparities, $20,000,000 of transformation funds to collaborations between safety-net hospitals and a larger hospital partner that increases specialty care in distressed communities, $30,000,000 of transformation funds to projects that are a collaboration between hospitals and other providers in distressed areas of the State designed to address specific health care disparities, $15,000,000 to collaborations between critical access hospitals and other providers designed to address specific health care disparities, and $15,000,000 to cross-provider collaborations designed to address specific health care disparities, and $5,000,000 to collaborations that focus on workforce development.

(iv) The Department may allocate up to $5,000,000 for planning, racial equity analysis, or consulting resources for the Department or entities without the resources to develop a plan to meet the criteria of this Section. Any contract for consulting services issued by the Department under this subparagraph shall comply with the

provisions of Section 5-45 of the State Officials and Employees Ethics Act. Based on availability of federal funding, the Department may directly procure consulting services or provide funding to the collaboration. The provision of resources under this subparagraph is not a guarantee that a project will be approved.

(v) The Department shall take steps to ensure that safety-net hospitals operating in under-resourced communities receive priority access to hospital and health care transformation funds, including consulting funds, as provided under this Section.

(G) Process for submitting and approving projects for distressed communities. The Department shall issue a template for application. The Department shall post any proposal received on the Department's website for at least 2 weeks for public comment, and any such public comment shall also be considered in the review process. Applicants may request that proprietary financial information be redacted from publicly posted proposals and the Department in its discretion may agree. Proposals for each distressed community must include all of the following:

(i) A detailed description of how the project intends to affect the goals outlined in this

subsection, describing new interventions, new technology, new structures, and other changes to the health care delivery system planned.

(ii) A detailed description of the racial and ethnic makeup of the entities' board and leadership positions and the salaries of the executive staff of entities in the partnership that is seeking to obtain funding under this Section.

(iii) A complete budget, including an overall timeline and a detailed pathway to sustainability within a 5-year period, specifying other sources of funding, such as in-kind, cost-sharing, or private donations, particularly for capital needs. There is an expectation that parties to the transformation project dedicate resources to the extent they are able and that these expectations are delineated separately for each entity in the proposal.

(iv) A description of any new entities formed or other legal relationships between collaborating entities and how funds will be allocated among participants.

(v) A timeline showing the evolution of sites and specific services of the project over a 5-year period, including services available to the

community by site.

(vi) Clear milestones indicating progress toward the proposed goals of the proposal as checkpoints along the way to continue receiving funding. The Department is authorized to refine these milestones in agreements, and is authorized to impose reasonable penalties, including repayment of funds, for substantial lack of progress.

(vii) A clear statement of the level of commitment the project will include for minorities and women in contracting opportunities, including as equity partners where applicable, or as subcontractors and suppliers in all phases of the project.

(viii) If the community study utilized is not the study commissioned and published by the Department, the applicant must define the methodology used, including documentation of clear community participation.

(ix) A description of the process used in collaborating with all levels of government in the community served in the development of the project, including, but not limited to, legislators and officials of other units of local government.

(x) Documentation of a community input process in the community served, including links to proposal materials on public websites.

(xi) Verifiable project milestones and quality metrics that will be impacted by transformation. These project milestones and quality metrics must be identified with improvement targets that must be met.

(xii) Data on the number of existing employees by various job categories and wage levels by the zip code of the employees' residence and benchmarks for the continued maintenance and improvement of these levels. The proposal must also describe any retraining or other workforce development planned for the new project.

(xiii) If a new entity is created by the project, a description of how the board will be reflective of the community served by the proposal.

(xiv) An explanation of how the proposal will address the existing disparities that exacerbated the impact of COVID-19 and the need for post-COVID care in the community, if applicable.

(xv) An explanation of how the proposal is designed to increase access to care, including specialty care based upon the community's needs.

(H) The Department shall evaluate proposals for compliance with the criteria listed under subparagraph (G). Proposals meeting all of the criteria may be eligible for funding with the areas of focus prioritized as described in item (ii) of subparagraph (F). Based on the funds available, the Department may negotiate funding agreements with approved applicants to maximize federal funding. Nothing in this subsection requires that an approved project be funded to the level requested. Agreements shall specify the amount of funding anticipated annually, the methodology of payments, the limit on the number of years such funding may be provided, and the milestones and quality metrics that must be met by the projects in order to continue to receive funding during each year of the program. Agreements shall specify the terms and conditions under which a health care facility that receives funds under a purchase of care agreement and closes in violation of the terms of the agreement must pay an early closure fee no greater than 50% of the funds it received under the agreement, prior to the Health Facilities and Services Review Board considering an application for closure of the facility. Any project that is funded shall be required to provide quarterly written progress reports, in a form prescribed by the Department, and at a minimum

shall include the progress made in achieving any milestones or metrics or Business Enterprise Program commitments in its plan. The Department may reduce or end payments, as set forth in transformation plans, if milestones or metrics or Business Enterprise Program commitments are not achieved. The Department shall seek to make payments from the transformation fund in a manner that is eligible for federal matching funds.

In reviewing the proposals, the Department shall take into account the needs of the community, data from the study commissioned by the Department from the University of Illinois-Chicago if applicable, feedback from public comment on the Department's website, as well as how the proposal meets the criteria listed under subparagraph (G). Alignment with the Department's overall strategic initiatives shall be an important factor. To the extent that fiscal year funding is not adequate to fund all eligible projects that apply, the Department shall prioritize applications that most comprehensively and effectively address the criteria listed under subparagraph (G).

(3) (Blank).

(4) Hospital Transformation Review Committee. There is created the Hospital Transformation Review Committee. The Committee shall consist of 14 members. No later than 30 days after March 12, 2018 (the effective date of Public

Act 100-581), the 4 legislative leaders shall each appoint 3 members; the Governor shall appoint the Director of Healthcare and Family Services, or his or her designee, as a member; and the Director of Healthcare and Family Services shall appoint one member. Any vacancy shall be filled by the applicable appointing authority within 15 calendar days. The members of the Committee shall select a Chair and a Vice-Chair from among its members, provided that the Chair and Vice-Chair cannot be appointed by the same appointing authority and must be from different political parties. The Chair shall have the authority to establish a meeting schedule and convene meetings of the Committee, and the Vice-Chair shall have the authority to convene meetings in the absence of the Chair. The Committee may establish its own rules with respect to meeting schedule, notice of meetings, and the disclosure of documents; however, the Committee shall not have the power to subpoena individuals or documents and any rules must be approved by 9 of the 14 members. The Committee shall perform the functions described in this Section and advise and consult with the Director in the administration of this Section. In addition to reviewing and approving the policies, procedures, and rules for the hospital and health care transformation program, the Committee shall consider and make recommendations related to qualifying criteria and payment methodologies related to safety-net

hospitals and children's hospitals. Members of the Committee appointed by the legislative leaders shall be subject to the jurisdiction of the Legislative Ethics Commission, not the Executive Ethics Commission, and all requests under the Freedom of Information Act shall be directed to the applicable Freedom of Information officer for the General Assembly. The Department shall provide operational support to the Committee as necessary. The Committee is dissolved on April 1, 2019.

(e) Beginning 36 months after initial implementation, the Department shall update the reimbursement components in subsections (a) and (b), including standardized amounts and weighting factors, and at least once every 4 years and no more frequently than annually thereafter. The Department shall publish these updates on its website no later than 30 calendar days prior to their effective date.

(f) Continuation of supplemental payments. Any supplemental payments authorized under 89 Illinois Administrative Code 148 effective January 1, 2014 and that continue during the period of July 1, 2014 through December 31, 2014 shall remain in effect as long as the assessment imposed by Section 5A-2 that is in effect on December 31, 2017 remains in effect.

(g) Notwithstanding subsections (a) through (f) of this Section and notwithstanding the changes authorized under Section 5-5b.1, any updates to the system shall not result in

any diminishment of the overall effective rates of reimbursement as of the implementation date of the new system (July 1, 2014). These updates shall not preclude variations in any individual component of the system or hospital rate variations. Nothing in this Section shall prohibit the Department from increasing the rates of reimbursement or developing payments to ensure access to hospital services. Nothing in this Section shall be construed to guarantee a minimum amount of spending in the aggregate or per hospital as spending may be impacted by factors, including, but not limited to, the number of individuals in the medical assistance program and the severity of illness of the individuals.

(h) The Department shall have the authority to modify by rulemaking any changes to the rates or methodologies in this Section as required by the federal government to obtain federal financial participation for expenditures made under this Section.

(i) Except for subsections (g) and (h) of this Section, the Department shall, pursuant to subsection (c) of Section 5-40 of the Illinois Administrative Procedure Act, provide for presentation at the June 2014 hearing of the Joint Committee on Administrative Rules (JCAR) additional written notice to JCAR of the following rules in order to commence the second notice period for the following rules: rules published in the Illinois Register, rule dated February 21, 2014 at 38 Ill.

Reg. 4559 (Medical Payment), 4628 (Specialized Health Care Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic Related Grouping (DRG) Prospective Payment System (PPS)), and 4977 (Hospital Reimbursement Changes), and published in the Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499 (Specialized Health Care Delivery Systems) and 6505 (Hospital Services).

(j) Out-of-state hospitals. Beginning July 1, 2018, for purposes of determining for State fiscal years 2019 and 2020 and subsequent fiscal years the hospitals eligible for the payments authorized under subsections (a) and (b) of this Section, the Department shall include out-of-state hospitals that are designated a Level I pediatric trauma center or a Level I trauma center by the Department of Public Health as of December 1, 2017.

(k) The Department shall notify each hospital and managed care organization, in writing, of the impact of the updates under this Section at least 30 calendar days prior to their effective date.

(k-5) The Department shall adopt amended rules, in advance of the development of annual Calendar Year 2027 hospital rates, to address the standardized process and time frame for updates to the reimbursement components described in subsections (a) and (b), including, but not limited to, the definition of "excessive growth" in paragraph (4) of subsection (a), in consultation with a statewide association

representing a majority of hospitals, to be undertaken prior to initiating rulemaking in accordance with the Illinois Administrative Procedure Act.

(l) This Section is subject to Section 14-12.5.

(Source: P.A. 103-102, eff. 6-16-23; 103-154, eff. 6-30-23; 104-9, eff. 6-16-25; 104-417, eff. 8-15-25.)

ARTICLE 30.

Section 30-5. The Illinois Public Aid Code is amended by changing Section 12-9 as follows:

(305 ILCS 5/12-9) (from Ch. 23, par. 12-9)

Sec. 12-9. Public Aid Recoveries Trust Fund; uses. The Public Aid Recoveries Trust Fund shall consist of (1) recoveries by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) authorized by this Code in respect to applicants or recipients under Articles III, IV, V, and VI, including recoveries made by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) from the estates of deceased recipients, (2) recoveries made by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) in respect to applicants and recipients under the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (2.5) recoveries made by the

Department of Healthcare and Family Services in connection with the imposition of an administrative penalty as provided under Section 12-4.45, (3) federal funds received on behalf of and earned by State universities, other State agencies or departments, and local governmental entities for services provided to applicants or recipients covered under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (3.5) federal financial participation revenue related to eligible disbursements made by the Department of Healthcare and Family Services from appropriations required by this Section, and (4) all other moneys received to the Fund, including interest thereon. The Fund shall be held as a special fund in the State Treasury.

Disbursements from this Fund shall be only (1) for the reimbursement of claims collected by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) through error or mistake, (2) for payment to persons or agencies designated as payees or co-payees on any instrument, whether or not negotiable, delivered to the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) as a recovery under this Section, such payment to be in proportion to the respective interests of the payees in the amount so collected, (3) for payments to the Department of Human Services for collections made by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) on behalf of the

Department of Human Services under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (4) for payment of administrative expenses incurred in performing the activities authorized under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (5) for payment of fees to persons or agencies in the performance of activities pursuant to the collection of monies owed the State that are collected under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (6) separate from those disbursements allowed under items (4) and (5), for payment of contingency fees to third-party entities that the Office of Inspector General authorizes to conduct audits under Sections 12-4.25 and 12-4.40, or any similar audits required by State or federal law, (7) for payments of any amounts which are reimbursable to the federal government which are required to be paid by State warrant by either the State or federal government, and (8) ~~(7)~~ for payments to State universities, other State agencies or departments, and local governmental entities of federal funds for services provided to applicants or recipients covered under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act. Disbursements from this Fund for purposes of items (4) and (5) of this paragraph shall be subject to appropriations from the Fund to the Department of Healthcare and Family Services (formerly

Illinois Department of Public Aid).

The balance in this Fund after payment therefrom of any amounts reimbursable to the federal government, and minus the amount anticipated to be needed to make the disbursements authorized by this Section, shall be certified by the Director of Healthcare and Family Services and transferred by the State Comptroller to the Drug Rebate Fund or the Healthcare Provider Relief Fund in the State Treasury, as appropriate, on at least an annual basis by June 30th of each fiscal year. The Director of Healthcare and Family Services may certify and the State Comptroller shall transfer to the Drug Rebate Fund or the Healthcare Provider Relief Fund amounts on a more frequent basis.

(Source: P.A. 103-593, eff. 6-7-24.)

ARTICLE 35.

Section 35-5. The Illinois Public Aid Code is amended by changing Section 5-5.4 as follows:

(305 ILCS 5/5-5.4) (from Ch. 23, par. 5-5.4)

Sec. 5-5.4. Standards of payment; Department of Healthcare and Family Services. The Department of Healthcare and Family Services shall develop standards of payment of nursing facility and ICF/DD services in facilities providing such services under this Article which:

(1) Provide for the determination of a facility's payment for nursing facility or ICF/DD services on a prospective basis. The amount of the payment rate for all nursing facilities certified by the Department of Public Health under the ID/DD Community Care Act or the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities, Long Term Care for Under Age 22 facilities, Skilled Nursing facilities, or Intermediate Care facilities under the medical assistance program shall be prospectively established annually on the basis of historical, financial, and statistical data reflecting actual costs from prior years, which shall be applied to the current rate year and updated for inflation, except that the capital cost element for newly constructed facilities shall be based upon projected budgets. The annually established payment rate shall take effect on July 1 in 1984 and subsequent years. No rate increase and no update for inflation shall be provided on or after July 1, 1994, unless specifically provided for in this Section. The changes made by Public Act 93-841 extending the duration of the prohibition against a rate increase or update for inflation are effective retroactive to July 1, 2004.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1, 1998 shall include an increase of 3%. For facilities licensed

by the Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 1998 shall include an increase of 3% plus $1.10 per resident-day, as defined by the Department. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care Facilities for the Developmentally Disabled or Long Term Care for Under Age 22 facilities, the rates taking effect on January 1, 2006 shall include an increase of 3%. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care Facilities for the Developmentally Disabled or Long Term Care for Under Age 22 facilities, the rates taking effect on January 1, 2009 shall include an increase sufficient to provide a $0.50 per hour wage increase for non-executive staff. For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities the rates taking effect within 30 days after July 6, 2017 (the effective date of Public Act 100-23) shall include an increase sufficient to provide a $0.75 per hour wage increase for non-executive staff. The Department shall adopt rules, including emergency rules under subsection (y) of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this paragraph. For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities and under the MC/DD Act as MC/DD Facilities, the rates taking

effect within 30 days after June 5, 2019 (the effective date of Public Act 101-10) shall include an increase sufficient to provide a $0.50 per hour wage increase for non-executive frontline personnel, including, but not limited to, direct support persons, aides, frontline supervisors, qualified intellectual disabilities professionals, nurses, and non-administrative support staff. The Department shall adopt rules, including emergency rules under subsection (bb) of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this paragraph.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1, 1999 shall include an increase of 1.6% plus $3.00 per resident-day, as defined by the Department. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 1999 shall include an increase of 1.6% and, for services provided on or after October 1, 1999, shall be increased by $4.00 per resident-day, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1,

2000 shall include an increase of 2.5% per resident-day, as defined by the Department. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 2000 shall include an increase of 2.5% per resident-day, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, a new payment methodology must be implemented for the nursing component of the rate effective July 1, 2003. The Department of Public Aid (now Healthcare and Family Services) shall develop the new payment methodology using the Minimum Data Set (MDS) as the instrument to collect information concerning nursing home resident condition necessary to compute the rate. The Department shall develop the new payment methodology to meet the unique needs of Illinois nursing home residents while remaining subject to the appropriations provided by the General Assembly. A transition period from the payment methodology in effect on June 30, 2003 to the payment methodology in effect on July 1, 2003 shall be provided for a period not exceeding 3 years and 184 days after implementation of the new payment methodology as follows:

(A) For a facility that would receive a lower nursing component rate per patient day under the new system than

the facility received effective on the date immediately preceding the date that the Department implements the new payment methodology, the nursing component rate per patient day for the facility shall be held at the level in effect on the date immediately preceding the date that the Department implements the new payment methodology until a higher nursing component rate of reimbursement is achieved by that facility.

(B) For a facility that would receive a higher nursing component rate per patient day under the payment methodology in effect on July 1, 2003 than the facility received effective on the date immediately preceding the date that the Department implements the new payment methodology, the nursing component rate per patient day for the facility shall be adjusted.

(C) Notwithstanding paragraphs (A) and (B), the nursing component rate per patient day for the facility shall be adjusted subject to appropriations provided by the General Assembly.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on March 1, 2001 shall include a statewide increase of 7.85%, as defined by the Department.

Notwithstanding any other provision of this Section, for

facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, except facilities participating in the Department's demonstration program pursuant to the provisions of Title 77, Part 300, Subpart T of the Illinois Administrative Code, the numerator of the ratio used by the Department of Healthcare and Family Services to compute the rate payable under this Section using the Minimum Data Set (MDS) methodology shall incorporate the following annual amounts as the additional funds appropriated to the Department specifically to pay for rates based on the MDS nursing component methodology in excess of the funding in effect on December 31, 2006:

(i) For rates taking effect January 1, 2007, $60,000,000.

(ii) For rates taking effect January 1, 2008, $110,000,000.

(iii) For rates taking effect January 1, 2009, $194,000,000.

(iv) For rates taking effect April 1, 2011, or the first day of the month that begins at least 45 days after February 16, 2011 (the effective date of Public Act 96-1530), $416,500,000 or an amount as may be necessary to complete the transition to the MDS methodology for the nursing component of the rate. Increased payments under this item (iv) are not due and payable, however, until (i)

the methodologies described in this paragraph are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed by Section 5B-2 of this Code is determined to be a permissible tax under Title XIX of the Social Security Act.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the support component of the rates taking effect on January 1, 2008 shall be computed using the most recent cost reports on file with the Department of Healthcare and Family Services no later than April 1, 2005, updated for inflation to January 1, 2006.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on April 1, 2002 shall include a statewide increase of 2.0%, as defined by the Department. This increase terminates on July 1, 2002; beginning July 1, 2002 these rates are reduced to the level of the rates in effect on March 31, 2002, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the rates taking effect on July 1, 2001 shall be computed using the most recent cost

reports on file with the Department of Public Aid no later than April 1, 2000, updated for inflation to January 1, 2001. For rates effective July 1, 2001 only, rates shall be the greater of the rate computed for July 1, 2001 or the rate effective on June 30, 2001.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the Illinois Department shall determine by rule the rates taking effect on July 1, 2002, which shall be 5.9% less than the rates in effect on June 30, 2002.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, if the payment methodologies required under Section 5A-12 and the waiver granted under 42 CFR 433.68 are approved by the United States Centers for Medicare and Medicaid Services, the rates taking effect on July 1, 2004 shall be 3.0% greater than the rates in effect on June 30, 2004. These rates shall take effect only upon approval and implementation of the payment methodologies required under Section 5A-12.

Notwithstanding any other provisions of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or

intermediate care facilities, the rates taking effect on January 1, 2005 shall be 3% more than the rates in effect on December 31, 2004.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, effective January 1, 2009, the per diem support component of the rates effective on January 1, 2008, computed using the most recent cost reports on file with the Department of Healthcare and Family Services no later than April 1, 2005, updated for inflation to January 1, 2006, shall be increased to the amount that would have been derived using standard Department of Healthcare and Family Services methods, procedures, and inflators.

Notwithstanding any other provisions of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as intermediate care facilities that are federally defined as Institutions for Mental Disease, or facilities licensed by the Department of Public Health under the Specialized Mental Health Rehabilitation Act of 2013, a socio-development component rate equal to 6.6% of the facility's nursing component rate as of January 1, 2006 shall be established and paid effective July 1, 2006. The socio-development component of the rate shall be increased by a factor of 2.53 on the first day of the month that begins at least 45 days after January 11, 2008 (the effective date of

Public Act 95-707). As of August 1, 2008, the socio-development component rate shall be equal to 6.6% of the facility's nursing component rate as of January 1, 2006, multiplied by a factor of 3.53. For services provided on or after April 1, 2011, or the first day of the month that begins at least 45 days after February 16, 2011 (the effective date of Public Act 96-1530), whichever is later, the Illinois Department may by rule adjust these socio-development component rates, and may use different adjustment methodologies for those facilities participating, and those not participating, in the Illinois Department's demonstration program pursuant to the provisions of Title 77, Part 300, Subpart T of the Illinois Administrative Code, but in no case may such rates be diminished below those in effect on August 1, 2008.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or as long-term care facilities for residents under 22 years of age, the rates taking effect on July 1, 2003 shall include a statewide increase of 4%, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on the first day of the month that begins at least 45 days after January 11,

2008 (the effective date of Public Act 95-707) shall include a statewide increase of 2.5%, as defined by the Department.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, effective January 1, 2005, facility rates shall be increased by the difference between (i) a facility's per diem property, liability, and malpractice insurance costs as reported in the cost report filed with the Department of Public Aid and used to establish rates effective July 1, 2001 and (ii) those same costs as reported in the facility's 2002 cost report. These costs shall be passed through to the facility without caps or limitations, except for adjustments required under normal auditing procedures.

Rates established effective each July 1 shall govern payment for services rendered throughout that fiscal year, except that rates established on July 1, 1996 shall be increased by 6.8% for services provided on or after January 1, 1997. Such rates will be based upon the rates calculated for the year beginning July 1, 1990, and for subsequent years thereafter until June 30, 2001 shall be based on the facility cost reports for the facility fiscal year ending at any point in time during the previous calendar year, updated to the midpoint of the rate year. The cost report shall be on file with the Department no later than April 1 of the current rate year. Should the cost report not be on file by April 1, the

Department shall base the rate on the latest cost report filed by each skilled care facility and intermediate care facility, updated to the midpoint of the current rate year. In determining rates for services rendered on and after July 1, 1985, fixed time shall not be computed at less than zero. The Department shall not make any alterations of regulations which would reduce any component of the Medicaid rate to a level below what that component would have been utilizing in the rate effective on July 1, 1984.

(2) Shall take into account the actual costs incurred by facilities in providing services for recipients of skilled nursing and intermediate care services under the medical assistance program.

(3) Shall take into account the medical and psycho-social characteristics and needs of the patients.

(4) Shall take into account the actual costs incurred by facilities in meeting licensing and certification standards imposed and prescribed by the State of Illinois, any of its political subdivisions or municipalities and by the U.S. Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

The Department of Healthcare and Family Services shall develop precise standards for payments to reimburse nursing facilities for any utilization of appropriate rehabilitative personnel for the provision of rehabilitative services which is authorized by federal regulations, including reimbursement

for services provided by qualified therapists or qualified assistants, and which is in accordance with accepted professional practices. Reimbursement also may be made for utilization of other supportive personnel under appropriate supervision.

The Department shall develop enhanced payments to offset the additional costs incurred by a facility serving exceptional need residents and shall allocate at least $4,000,000 of the funds collected from the assessment established by Section 5B-2 of this Code for such payments. For the purpose of this Section, "exceptional needs" means, but need not be limited to, ventilator care and traumatic brain injury care. The enhanced payments for exceptional need residents under this paragraph are not due and payable, however, until (i) the methodologies described in this paragraph are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed by Section 5B-2 of this Code is determined to be a permissible tax under Title XIX of the Social Security Act.

Beginning January 1, 2014 the methodologies for reimbursement of nursing facility services as provided under this Section 5-5.4 shall no longer be applicable for services provided on or after January 1, 2014.

No payment increase under this Section for the MDS methodology, exceptional care residents, or the socio-development component rate established by Public Act

96-1530 of the 96th General Assembly and funded by the assessment imposed under Section 5B-2 of this Code shall be due and payable until after the Department notifies the long-term care providers, in writing, that the payment methodologies to long-term care providers required under this Section have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. Upon notification to the Department of approval of the payment methodologies required under this Section and the waivers granted under 42 CFR 433.68, all increased payments otherwise due under this Section prior to the date of notification shall be due and payable within 90 days of the date federal approval is received.

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.

For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities and under the MC/DD Act as MC/DD Facilities, subject to federal approval, the rates taking effect for services delivered on or

after August 1, 2019 shall be increased by 3.5% over the rates in effect on June 30, 2019. The Department shall adopt rules, including emergency rules under subsection (ii) of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section, including wage increases for direct care staff.

For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities and under the MC/DD Act as MC/DD Facilities, subject to federal approval, the rates taking effect on the latter of the approval date of the State Plan Amendment for these facilities or the Waiver Amendment for the home and community-based services settings shall include an increase sufficient to provide a $0.26 per hour wage increase to the base wage for non-executive staff. The Department shall adopt rules, including emergency rules as authorized by Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section, including wage increases for direct care staff.

For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities and under the MC/DD Act as MC/DD Facilities, subject to federal approval of the State Plan Amendment and the Waiver Amendment for the home and community-based services settings, the rates taking effect for the services delivered on or after July 1, 2020 shall include an increase sufficient to provide a $1.00

per hour wage increase for non-executive staff. For services delivered on or after January 1, 2021, subject to federal approval of the State Plan Amendment and the Waiver Amendment for the home and community-based services settings, shall include an increase sufficient to provide a $0.50 per hour increase for non-executive staff. The Department shall adopt rules, including emergency rules as authorized by Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section, including wage increases for direct care staff.

For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities and under the MC/DD Act as MC/DD Facilities, subject to federal approval of the State Plan Amendment, the rates taking effect for the residential services delivered on or after July 1, 2021, shall include an increase sufficient to provide a $0.50 per hour increase for aides in the rate methodology. For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities and under the MC/DD Act as MC/DD Facilities, subject to federal approval of the State Plan Amendment, the rates taking effect for the residential services delivered on or after January 1, 2022 shall include an increase sufficient to provide a $1.00 per hour increase for aides in the rate methodology. In addition, for residential services delivered on or after January 1, 2022 such rates shall include an increase sufficient to provide

wages for all residential non-executive direct care staff, excluding aides, at the federal Department of Labor, Bureau of Labor Statistics' average wage as defined in rule by the Department. The Department shall adopt rules, including emergency rules as authorized by Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section.

For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD facilities and under the MC/DD Act as MC/DD facilities, subject to federal approval of the State Plan Amendment, the rates taking effect for services delivered on or after January 1, 2023, shall include a $1.00 per hour wage increase for all direct support personnel and all other frontline personnel who are not subject to the Bureau of Labor Statistics' average wage increases, who work in residential and community day services settings, with at least $0.50 of those funds to be provided as a direct increase to all aide base wages, with the remaining $0.50 to be used flexibly for base wage increases to the rate methodology for aides. In addition, for residential services delivered on or after January 1, 2023 the rates shall include an increase sufficient to provide wages for all residential non-executive direct care staff, excluding aides, at the federal Department of Labor, Bureau of Labor Statistics' average wage as determined by the Department. Also, for services delivered on or after January 1, 2023, the rates will

include adjustments to employment-related expenses as defined in rule by the Department. The Department shall adopt rules, including emergency rules as authorized by Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section.

For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD facilities and under the MC/DD Act as MC/DD facilities, subject to federal approval of the State Plan Amendment, the rates taking effect for services delivered on or after January 1, 2024 shall include a $2.50 per hour wage increase for all direct support personnel and all other frontline personnel who are not subject to the Bureau of Labor Statistics' average wage increases and who work in residential and community day services settings. At least $1.25 of the per hour wage increase shall be provided as a direct increase to all aide base wages, and the remaining $1.25 of the per hour wage increase shall be used flexibly for base wage increases to the rate methodology for aides. In addition, for residential services delivered on or after January 1, 2024, the rates shall include an increase sufficient to provide wages for all residential non-executive direct care staff, excluding aides, at the federal Department of Labor, Bureau of Labor Statistics' average wage as determined by the Department. Also, for services delivered on or after January 1, 2024, the rates will include adjustments to employment-related expenses

as defined in rule by the Department. The Department shall adopt rules, including emergency rules as authorized by Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section.

For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD facilities and under the MC/DD Act as MC/DD facilities, subject to federal approval of a State Plan Amendment, the rates taking effect for services delivered on or after January 1, 2025 shall include a $1.00 per hour wage increase for all direct support personnel and all other frontline personnel who are not subject to the Bureau of Labor Statistics' average wage increases and who work in residential and community day services settings, with at least $0.75 of those funds to be provided as a direct increase to all aide base wages and the remaining $0.25 to be used flexibly for base wage increases to the rate methodology for aides. These increases shall not be used by facilities for operational and administrative expenses. In addition, for residential services delivered on or after January 1, 2025, the rates shall include an increase sufficient to provide wages for all residential non-executive direct care staff, excluding aides, at the federal Department of Labor, Bureau of Labor Statistics' average wage as determined by the Department. Also, for services delivered on or after January 1, 2025, the rates will include adjustments to employment-related expenses as defined in rule by the

Department. The Department shall adopt rules, including emergency rules as authorized by Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section.

For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD facilities and under the MC/DD Act as MC/DD facilities, subject to federal approval of a State Plan Amendment, the rates taking effect for services delivered on or after January 1, 2026 shall include a $0.80 per hour wage increase for all direct support personnel and all other frontline personnel who are not subject to the Bureau of Labor Statistics' average wage increases and who work in residential and community day services settings, with at least $0.60 of those funds to be provided as a direct increase to all aide base wages and the remaining $0.20 to be used flexibly for base wage increases to the rate methodology for aides. These increases shall not be used by facilities for operational and administrative expenses. In addition, for residential services delivered on or after January 1, 2026, the rates shall include an increase sufficient to provide wages for all residential non-executive direct care staff, excluding aides, at the federal Department of Labor, Bureau of Labor Statistics' average wage as determined by the Department. Also, for services delivered on or after January 1, 2026, the rates will include adjustments to employment-related expenses as defined in rule by the

Department. The Department shall adopt rules, including emergency rules as authorized by Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section.

Notwithstanding any other provision of this Section to the contrary, any regional wage adjuster for facilities located outside of the counties of Cook, DuPage, Kane, Lake, McHenry, and Will shall be no lower than 1.00, and any regional wage adjuster for facilities located within the counties of Cook, DuPage, Kane, Lake, McHenry, and Will shall be no lower than 1.15.

(5) For dates of service starting July 1, 2027, reimbursement calculations and direct payments for services provided by facilities licensed under the ID/DD Community Care Act are the responsibility of the Department of Healthcare and Family Services. Appropriations for facilities licensed under the ID/DD Community Care Act must be shifted from the Department of Human Services to the Department of Healthcare and Family Services. Nothing in this Section shall prohibit the Department of Healthcare and Family Services from paying more than the rates specified in this Section. Nothing in this Section shall affect the requirements of Section 3-213 of the ID/DD Community Care Act.

(Source: P.A. 103-8, eff. 6-7-23; 103-588, eff. 7-1-24; 104-2, eff. 6-16-25.)

ARTICLE 40.

Section 40-5. The Illinois Public Aid Code is amended by changing Section 5-5e.1 as follows:

(305 ILCS 5/5-5e.1)

Sec. 5-5e.1. Safety-Net Hospitals.

(a) A Safety-Net Hospital is an Illinois hospital that:

(1) is licensed by the Department of Public Health as a general acute care or pediatric hospital; and

(2) is a disproportionate share hospital, as described in Section 1923 of the federal Social Security Act, as determined by the Department; and

(3) meets one of the following:

(A) has a MIUR of at least 40% and a charity percent of at least 4%; or

(B) has a MIUR of at least 50%.

(b) Definitions. As used in this Section:

(1) "Charity percent" means the ratio of (i) the hospital's charity charges for services provided to individuals without health insurance or another source of third party coverage to (ii) the Illinois total hospital charges, each as reported on the hospital's OBRA form.

(2) "MIUR" means Medicaid Inpatient Utilization Rate and is defined as a fraction, the numerator of which is the number of a hospital's inpatient days provided in the

hospital's fiscal year ending 3 years prior to the rate year, to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act, 42 USC 1396a et seq., excluding those persons eligible for medical assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of Section 5-2 of this Article, and the denominator of which is the total number of the hospital's inpatient days in that same period, excluding those persons eligible for medical assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of Section 5-2 of this Article.

(3) "OBRA form" means form HFS-3834, OBRA '93 data collection form, for the rate year.

(4) "Rate year" means the 12-month period beginning on October 1.

(c) Beginning July 1, 2012 and ending on December 31, 2028 ~~2026~~, a hospital that would have qualified for the rate year beginning October 1, 2011 or October 1, 2012 shall be a Safety-Net Hospital.

(c-5) Beginning July 1, 2020 and ending on December 31, 2026, a hospital that would have qualified for the rate year beginning October 1, 2020 and was designated a federal rural referral center under 42 CFR 412.96 as of October 1, 2020 shall be a Safety-Net Hospital.

(d) No later than August 15 preceding the rate year, each

hospital shall submit the OBRA form to the Department. Prior to October 1, the Department shall notify each hospital whether it has qualified as a Safety-Net Hospital.

(e) The Department may promulgate rules in order to implement this Section.

(f) Nothing in this Section shall be construed as limiting the ability of the Department to include the Safety-Net Hospitals in the hospital rate reform mandated by Section 14-11 of this Code and implemented under Section 14-12 of this Code and by administrative rulemaking.

(Source: P.A. 101-650, eff. 7-7-20; 101-669, eff. 4-2-21; 102-886, eff. 5-17-22.)

ARTICLE 45.

Section 45-5. The Hospital Licensing Act is amended by changing Section 6.09 as follows:

(210 ILCS 85/6.09) (from Ch. 111 1/2, par. 147.09)

Sec. 6.09. (a) In order to facilitate the orderly transition of aged patients and patients with disabilities from hospitals to post-hospital care, whenever a patient who qualifies for the federal Medicare program is hospitalized, the patient shall be notified of discharge at least 24 hours prior to discharge from the hospital. With regard to pending discharges to a skilled nursing facility, the hospital must

notify the case coordination unit, as defined in 89 Ill. Adm. Code 240.260, at least 24 hours prior to discharge. When the assessment is completed in the hospital, the case coordination unit shall provide a copy of the required assessment documentation directly to the nursing home to which the patient is being discharged prior to discharge. The Department on Aging shall provide notice of this requirement to case coordination units. When a case coordination unit is unable to complete an assessment in a hospital prior to the discharge of a patient, 60 years of age or older, to a nursing home, the case coordination unit shall notify the Department on Aging which shall notify the Department of Healthcare and Family Services. ~~The Department on Aging shall adopt rules to address these instances to ensure that the patient is able to access nursing home care, the nursing home is not penalized for accepting the admission, and the patient's timely discharge from the hospital is not delayed, to the extent permitted under federal law or regulation.~~ Nothing in this subsection shall preclude federal requirements for a pre-admission screening/mental health (PAS/MH) as required under Section 2-201.5 of the Nursing Home Care Act or State or federal law or regulation. If home health services are ordered, the hospital must inform its designated case coordination unit, as defined in 89 Ill. Adm. Code 240.260, of the pending discharge and must provide the patient with the case coordination unit's telephone number and other contact information.

(b) Every hospital shall develop procedures for a physician with medical staff privileges at the hospital or any appropriate medical staff member to provide the discharge notice prescribed in subsection (a) of this Section. The procedures must include prohibitions against discharging or referring a patient to any of the following if unlicensed, uncertified, or unregistered: (i) a board and care facility, as defined in the Board and Care Home Act; (ii) an assisted living and shared housing establishment, as defined in the Assisted Living and Shared Housing Act; (iii) a facility licensed under the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, the ID/DD Community Care Act, or the MC/DD Act; (iv) a supportive living facility, as defined in Section 5-5.01a of the Illinois Public Aid Code; or (v) a free-standing hospice facility licensed under the Hospice Program Licensing Act if licensure, certification, or registration is required. The Department of Public Health shall annually provide hospitals with a list of licensed, certified, or registered board and care facilities, assisted living and shared housing establishments, nursing homes, supportive living facilities, facilities licensed under the ID/DD Community Care Act, the MC/DD Act, or the Specialized Mental Health Rehabilitation Act of 2013, and hospice facilities. Reliance upon this list by a hospital shall satisfy compliance with this requirement. The procedure may also include a waiver for any case in which a discharge notice

is not feasible due to a short length of stay in the hospital by the patient, or for any case in which the patient voluntarily desires to leave the hospital before the expiration of the 24 hour period.

(c) At least 24 hours prior to discharge from the hospital, the patient shall receive written information on the patient's right to appeal the discharge pursuant to the federal Medicare program, including the steps to follow to appeal the discharge and the appropriate telephone number to call in case the patient intends to appeal the discharge.

(d) Before transfer of a patient to a long term care facility licensed under the Nursing Home Care Act where elderly persons reside, a hospital shall as soon as practicable initiate a name-based criminal history background check by electronic submission to the Illinois State Police for all persons between the ages of 18 and 70 years; provided, however, that a hospital shall be required to initiate such a background check only with respect to patients who:

(1) are transferring to a long term care facility for the first time;

(2) have been in the hospital more than 5 days;

(3) are reasonably expected to remain at the long term care facility for more than 30 days;

(4) have a known history of serious mental illness or substance abuse; and

(5) are independently ambulatory or mobile for more

than a temporary period of time.

A hospital may also request a criminal history background check for a patient who does not meet any of the criteria set forth in items (1) through (5).

A hospital shall notify a long term care facility if the hospital has initiated a criminal history background check on a patient being discharged to that facility. In all circumstances in which the hospital is required by this subsection to initiate the criminal history background check, the transfer to the long term care facility may proceed regardless of the availability of criminal history results. Upon receipt of the results, the hospital shall promptly forward the results to the appropriate long term care facility. If the results of the background check are inconclusive, the hospital shall have no additional duty or obligation to seek additional information from, or about, the patient.

(Source: P.A. 102-538, eff. 8-20-21; 103-102, eff. 1-1-24.)

ARTICLE 50.

Section 50-5. The Illinois Public Aid Code is amended by changing Section 5-5.24 as follows:

(305 ILCS 5/5-5.24)

Sec. 5-5.24. Prenatal and perinatal care.

(a) The Department of Healthcare and Family Services may provide reimbursement under this Article for all prenatal and perinatal health care services that are provided for the purpose of preventing low-birthweight infants, reducing the need for neonatal intensive care hospital services, and promoting perinatal and maternal health. These services may include comprehensive risk assessments for pregnant individuals, individuals with infants, and infants, lactation counseling, nutrition counseling, childbirth support, psychosocial counseling, treatment and prevention of periodontal disease, language translation, nurse home visitation, and other support services that have been proven to improve birth and maternal health outcomes. The Department shall maximize the use of preventive prenatal and perinatal health care services consistent with federal statutes, rules, and regulations. The Department of Public Aid (now Department of Healthcare and Family Services) shall develop a plan for prenatal and perinatal preventive health care and shall present the plan to the General Assembly by January 1, 2004. On or before January 1, 2006 and every 2 years thereafter, the Department shall report to the General Assembly concerning the effectiveness of prenatal and perinatal health care services reimbursed under this Section in preventing low-birthweight infants and reducing the need for neonatal intensive care hospital services. Each such report shall include an evaluation of how the ratio of expenditures for treating

low-birthweight infants compared with the investment in promoting healthy births and infants in local community areas throughout Illinois relates to healthy infant development in those areas.

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.

(b)(1) As used in this subsection:

"Affiliated provider" means a provider who is enrolled in the medical assistance program and has an active contract with a managed care organization.

"Non-affiliated provider" means a provider who is enrolled in the medical assistance program but does not have a contract with an MCO.

"Preventive prenatal and perinatal health care services" means services described in subsection (a) including the following non-emergent diagnostic and ancillary services:

(i) Diagnostic labs and imaging, including level II ultrasounds.

(ii) RhoGAM injections.

(iii) Injectable 17-alpha-hydroxyprogesterone caproate (commonly called 17P).

(iv) Intrapartum (labor and delivery) services.

(v) Any other outpatient or inpatient service relating

to pregnancy or the 12 months following childbirth or fetal loss.

(2) In order to maximize the accessibility of preventive prenatal and perinatal health care services, the Department of Healthcare and Family Services shall amend its managed care contracts such that an MCO must pay for preventive prenatal services, perinatal healthcare services, and postpartum services rendered by a non-affiliated provider, for which the health plan would pay if rendered by an affiliated provider, at the rate paid under the Illinois Medicaid fee-for-service program methodology for such services, including all policy adjusters, including, but not limited to, Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates, unless a different rate was agreed upon by the health plan and the non-affiliated provider.

(3) In cases where a managed care organization must pay for preventive prenatal services, perinatal healthcare services, and postpartum services rendered by a non-affiliated provider, the requirements under paragraph (2) shall not apply if the services were not emergency services, as defined in Section 5-30.1, and:

(A) the non-affiliated provider is a perinatal hospital and has, within the 12 months preceding the date

of service, rejected a contract that was offered in good faith by the health plan as determined by the Department; or

(B) the health plan has terminated a contract with the non-affiliated provider for cause, and the Department has not deemed the termination to have been without merit. The Department may deem that a determination for cause has merit if:

(i) an institutional provider has repeatedly failed to conduct discharge planning; or

(ii) the provider's conduct adversely and substantially impacts the health of Medicaid patients; or

(iii) the provider's conduct constitutes fraud, waste, or abuse; or

(iv) the provider's conduct violates the code of ethics governing his or her profession.

(4) For dates of service on and after January 1, 2026, the medical assistance program shall provide coverage, without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement, for preeclampsia biomarker testing for predictive screening in asymptomatic individuals, or for diagnosis and management when symptoms are present.

(Source: P.A. 102-665, eff. 10-8-21; 102-964, eff. 1-1-23.)

ARTICLE 55.

Section 55-5. The Specialized Mental Health Rehabilitation Act of 2013 is amended by changing Sections 2-101 and 3-104 as follows:

(210 ILCS 49/2-101)

Sec. 2-101. Standards for facilities.

(a) The Department shall, by rule, prescribe minimum standards for each level of care for facilities to be in place during the provisional licensure period and thereafter. These standards shall include, but are not limited to, the following:

(1) life safety standards that will ensure the health, safety and welfare of residents and their protection from hazards;

(2) number and qualifications of all personnel, including management and clinical personnel, having responsibility for any part of the care given to consumers; specifically, the Department shall establish staffing ratios for facilities which shall specify the number of staff hours per consumer of care that are needed for each level of care offered within the facility;

(3) all sanitary conditions within the facility and its surroundings, including water supply, sewage disposal, food handling, and general hygiene which shall ensure the health and comfort of consumers;

(4) a program for adequate maintenance of physical plant and equipment;

(5) adequate accommodations, staff, and services for the number and types of services being offered to consumers for whom the facility is licensed to care;

(6) development of evacuation and other appropriate safety plans for use during weather, health, fire, physical plant, environmental, and national defense emergencies;

(7) maintenance of minimum financial or other resources necessary to meet the standards established under this Section, and to operate and conduct the facility in accordance with this Act;

(8) standards for coercive free environment, restraint, and therapeutic separation; and

(9) each multiple bedroom shall have at least 55 square feet of net floor area per consumer, not including space for closets, bathrooms, and clearly defined entryway areas. A minimum of 3 feet of clearance at the foot and one side of each bed shall be provided.

(b) Any requirement contained in administrative rule concerning a percentage of single occupancy rooms shall be calculated based on the total number of licensed or provisionally licensed beds under this Act on January 1, 2019 and shall not be calculated on a per-facility basis.

(c) A facility licensed under this Act shall not accept

any person experiencing an acute medical condition liable to cause death, severe injury, or serious illness.

(Source: P.A. 101-10, eff. 6-5-19; 102-558, eff. 8-20-21.)

(210 ILCS 49/3-104)

Sec. 3-104. Care, treatment, and records. Facilities shall provide, at a minimum, the following services: physician, nursing, pharmaceutical, rehabilitative, and dietary services. To provide these services, the facility shall adhere to the following:

(1) Each consumer shall be encouraged and assisted to achieve and maintain the highest level of self-care and independence. Every effort shall be made to keep consumers active and out of bed for reasonable periods of time, except when contraindicated by physician orders.

(2) Every consumer shall be engaged in a person-centered planning process regarding his or her total care and treatment.

(3) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to ensure facility compliance with such orders. According to rules adopted by the Department, every woman consumer of child bearing age shall receive routine obstetrical and gynecological

evaluations as well as necessary prenatal care.

(4) Each consumer shall be provided with good nutrition and with necessary fluids for hydration.

(5) Each consumer shall be provided visual privacy during treatment and personal care.

(6) Every consumer or consumer's guardian shall be permitted to inspect and copy all his or her clinical and other records concerning his or her care kept by the facility or by his or her physician. The facility may charge a reasonable fee for duplication of a record.

(7) Each consumer shall be offered at least 15 hours of treatment programming per week and shall be encouraged to attend the treatment domains that meet the consumer's needs, as reflected in the consumer's treatment plans. Each consumer's program engagement and attendance shall be documented in the consumer's clinical record, and each consumer shall be prompted to attend programming regularly as documented in the consumer's clinical record at least quarterly.

(Source: P.A. 98-104, eff. 7-22-13.)

ARTICLE 60.

Section 60-5. The Illinois Public Aid Code is amended by adding Section 5-5.25a as follows:

(305 ILCS 5/5-5.25a new)

Sec. 5-5.25a. Coverage for seizure detection devices.

(a) As used in this Section, "seizure detection device" means a monitoring device cleared by the United States Food and Drug Administration, and any related technology, application, service, or subscription supporting the prescribed use of the device, that provides the following:

(1) individual monitoring and alert services relating to seizure activity;

(2) detection or prediction of seizure activity and transmission of notification of the seizure activity to the individual or a caregiver for appropriate medical response; or

(3) collection of data of the seizure activity of the individual that can be used by a health care provider to diagnose or appropriately treat a health care condition that causes the seizure activity.

(b) All seizure detection devices covered under this Section shall be approved for use by individuals, provided that the device has been prescribed and determined to be medically necessary. The choice of device shall be made based upon the individual's circumstances and medical needs in consultation with the individual's medical provider.

(c) Any individual who has been prescribed a seizure detection device shall not be required to obtain prior authorization for coverage for a seizure detection device, and

coverage shall be continuous once the seizure detection device is prescribed.

(d) Notwithstanding any other provision of this Section, commencing July 1, 2027, all seizure detection devices cleared by the United States Food and Drug Administration shall be covered under the medical assistance program for persons who have been prescribed a seizure detection device and who are otherwise eligible for assistance under this Article.

(e) The Department shall not adopt rules or classification policies that would limit the ability of individuals covered by this Section to obtain seizure detection devices.

ARTICLE 65.

Section 65-5. The Community-Integrated Living Arrangements Licensure and Certification Act is amended by changing Section 13.3 as follows:

(210 ILCS 135/13.3)

Sec. 13.3. Community-integrated living arrangement per diem reimbursement. As used in this Section, "medical absence" means a situation in which a resident is temporarily absent from a community-integrated living arrangement to receive medical treatment or for other reasons that have been recommended by third-party medical personnel, including, but not limited to, hospitalizations, placements in short-term

stabilization homes or State-operated facilities, stays in nursing facilities, rehabilitation in long-term care facilities, or other absences for legitimate medical reasons.

Beginning January 1, 2025, the Department's Division of Developmental Disabilities shall provide 100% of the per diem reimbursement to a 24-hour community-integrated living arrangement provider for up to 20 days for any resident requiring a medical absence. During the medical absence, the provider shall hold the bed for the resident. After the medical absence, the resident shall return to the community-integrated living arrangement when the resident is medically able to return in order for the provider to receive the full per diem reimbursement for the absent days. However, if it is determined by a treating physician that the resident is unable to return to the community-integrated living arrangement, or if the resident dies during the medical absence, the provider shall receive 100% of the per diem reimbursement for up to 20 medical absence days. The per diem reimbursement shall be in addition to the existing occupancy factor policy set by the Division of Developmental Disabilities. Any Department policy or rulemaking issued to implement this Section shall provide that for medical absences a resident's termination date is the date the resident either passes away or the date it is determined by a treating physician that the resident is unable to return to the community-integrated living arrangement.

(Source: P.A. 103-593, eff. 6-7-24.)

ARTICLE 75.

Section 75-5. The Illinois Public Aid Code is amended by changing Section 5-5.02 as follows:

(305 ILCS 5/5-5.02) (from Ch. 23, par. 5-5.02)

Sec. 5-5.02. Hospital reimbursements.

(a) Reimbursement to hospitals; July 1, 1992 through September 30, 1992. Notwithstanding any other provisions of this Code or the Illinois Department's Rules promulgated under the Illinois Administrative Procedure Act, reimbursement to hospitals for services provided during the period July 1, 1992 through September 30, 1992, shall be as follows:

(1) For inpatient hospital services rendered, or if applicable, for inpatient hospital discharges occurring, on or after July 1, 1992 and on or before September 30, 1992, the Illinois Department shall reimburse hospitals for inpatient services under the reimbursement methodologies in effect for each hospital, and at the inpatient payment rate calculated for each hospital, as of June 30, 1992. For purposes of this paragraph, "reimbursement methodologies" means all reimbursement methodologies that pertain to the provision of inpatient hospital services, including, but not limited to, any

adjustments for disproportionate share, targeted access, critical care access and uncompensated care, as defined by the Illinois Department on June 30, 1992.

(2) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly adjustment payments for targeted access and critical care, as defined by the Illinois Department on June 30, 1992, the adjustment payment for the period July 1, 1992 through September 30, 1992, shall be 25% of the annual adjustment payments calculated for each eligible hospital, as of June 30, 1992. The Illinois Department shall determine by rule the adjustment payments for targeted access and critical care beginning October 1, 1992.

(3) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly adjustment payments for uncompensated care, as defined by the Illinois Department on June 30, 1992, the adjustment payment for the period August 1, 1992 through September 30, 1992, shall be one-sixth of the total uncompensated care adjustment payments calculated for each eligible hospital for the uncompensated care rate year, as defined by the Illinois Department, ending on July 31, 1992. The Illinois Department shall determine by rule the adjustment payments for uncompensated care beginning October 1, 1992.

(b) Inpatient payments. For inpatient services provided on or after October 1, 1993, in addition to rates paid for hospital inpatient services pursuant to the Illinois Health Finance Reform Act, as now or hereafter amended, or the Illinois Department's prospective reimbursement methodology, or any other methodology used by the Illinois Department for inpatient services, the Illinois Department shall make adjustment payments, in an amount calculated pursuant to the methodology described in paragraph (c) of this Section, to hospitals that the Illinois Department determines satisfy any one of the following requirements:

(1) Hospitals that are described in Section 1923 of the federal Social Security Act, as now or hereafter amended, except that for rate year 2015 and after a hospital described in Section 1923(b)(1)(B) of the federal Social Security Act and qualified for the payments described in subsection (c) of this Section for rate year 2014 provided the hospital continues to meet the description in Section 1923(b)(1)(B) in the current determination year; or

(2) Illinois hospitals that have a Medicaid inpatient utilization rate which is at least one-half a standard deviation above the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Illinois Department; or

(3) Illinois hospitals that on July 1, 1991 had a

Medicaid inpatient utilization rate, as defined in paragraph (h) of this Section, that was at least the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Illinois Department and which were located in a planning area with one-third or fewer excess beds as determined by the Health Facilities and Services Review Board, and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area; or

(4) Illinois hospitals that:

(A) have a Medicaid inpatient utilization rate that is at least equal to the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Department; and

(B) also have a Medicaid obstetrical inpatient utilization rate that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Department for obstetrical services; or

(5) Any children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children if either (i) the facility devoted exclusively

to caring for children is separately licensed as a hospital by a municipality prior to February 28, 2013; (ii) the hospital has been designated by the State as a Level III perinatal care facility, has a Medicaid Inpatient Utilization rate greater than 55% for the rate year 2003 disproportionate share determination, and has more than 10,000 qualified children days as defined by the Department in rulemaking; (iii) the hospital has been designated as a Perinatal Level III center by the State as of December 1, 2017, is a Pediatric Critical Care Center designated by the State as of December 1, 2017 and has a 2017 Medicaid inpatient utilization rate equal to or greater than 45%; or (iv) the hospital has been designated as a Perinatal Level II center by the State as of December 1, 2017, has a 2017 Medicaid Inpatient Utilization Rate greater than 70%, and has at least 10 pediatric beds as listed on the IDPH 2015 calendar year hospital profile; or

(6) A hospital that reopens a previously closed hospital facility within 4 calendar years of the hospital facility's closure, if the previously closed hospital facility qualified for payments under paragraph (c) at the time of closure, until utilization data for the new facility is available for the Medicaid inpatient utilization rate calculation. For purposes of this clause, a "closed hospital facility" shall include hospitals that have been terminated from participation in the medical

assistance program in accordance with Section 12-4.25 of this Code.

(c) Inpatient adjustment payments. The adjustment payments required by paragraph (b) shall be calculated based upon the hospital's Medicaid inpatient utilization rate as follows:

(1) hospitals with a Medicaid inpatient utilization rate below the mean shall receive a per day adjustment payment equal to $25;

(2) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;

(3) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $40 plus $7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate;

(4) hospitals with a Medicaid inpatient utilization

rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $90 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate; and

(5) hospitals qualifying under clause (6) of paragraph (b) shall have the rate assigned to the previously closed hospital facility at the date of closure, until utilization data for the new facility is available for the Medicaid inpatient utilization rate calculation.

(c-1) Beginning October 1, 2026, for rate year 2027 and thereafter, the Medicaid inpatient utilization rate used in the determination of eligibility for payments under paragraph (c) shall be modified to exclude from both the numerator and denominator all days of care funded by the U.S. Department of Veterans Affairs at a hospital approved to conduct its operations from more than one location within contiguous counties under a single license, if at the time of its licensing application the hospital was located in a county with fewer than 125,000 inhabitants and the hospital's second facility is located in a contiguous county with fewer than 235,000 inhabitants. For purposes of this subsection, days of care funded by the U.S. Department of Veterans Affairs include authorized VA community care provided at non-VA hospitals.

(d) Supplemental adjustment payments. In addition to the adjustment payments described in paragraph (c), hospitals as defined in clauses (1) through (6) of paragraph (b), excluding county hospitals (as defined in subsection (c) of Section 15-1 of this Code) and a hospital organized under the University of Illinois Hospital Act, shall be paid supplemental inpatient adjustment payments of $60 per day. For purposes of Title XIX of the federal Social Security Act, these supplemental adjustment payments shall not be classified as adjustment payments to disproportionate share hospitals.

(e) The inpatient adjustment payments described in paragraphs (c) and (d) shall be increased on October 1, 1993 and annually thereafter by a percentage equal to the lesser of (i) the increase in the DRI hospital cost index for the most recent 12 month period for which data are available, or (ii) the percentage increase in the statewide average hospital payment rate over the previous year's statewide average hospital payment rate. The sum of the inpatient adjustment payments under paragraphs (c) and (d) to a hospital, other than a county hospital (as defined in subsection (c) of Section 15-1 of this Code) or a hospital organized under the University of Illinois Hospital Act, however, shall not exceed $275 per day; that limit shall be increased on October 1, 1993 and annually thereafter by a percentage equal to the lesser of (i) the increase in the DRI hospital cost index for the most recent 12-month period for which data are available or (ii)

the percentage increase in the statewide average hospital payment rate over the previous year's statewide average hospital payment rate.

(f) Children's hospital inpatient adjustment payments. For children's hospitals, as defined in clause (5) of paragraph (b), the adjustment payments required pursuant to paragraphs (c) and (d) shall be multiplied by 2.0.

(g) County hospital inpatient adjustment payments. For county hospitals, as defined in subsection (c) of Section 15-1 of this Code, there shall be an adjustment payment as determined by rules issued by the Illinois Department.

(h) For the purposes of this Section the following terms shall be defined as follows:

(1) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act, and the denominator of which is the total number of the hospital's inpatient days in that same period.

(2) "Mean Medicaid inpatient utilization rate" means the total number of Medicaid inpatient days provided by all Illinois Medicaid-participating hospitals divided by the total number of inpatient days provided by those same hospitals.

(3) "Medicaid obstetrical inpatient utilization rate"

means the ratio of Medicaid obstetrical inpatient days to total Medicaid inpatient days for all Illinois hospitals receiving Medicaid payments from the Illinois Department.

(i) Inpatient adjustment payment limit. In order to meet the limits of Public Law 102-234 and Public Law 103-66, the Illinois Department shall by rule adjust disproportionate share adjustment payments.

(j) University of Illinois Hospital inpatient adjustment payments. For hospitals organized under the University of Illinois Hospital Act, there shall be an adjustment payment as determined by rules adopted by the Illinois Department.

(k) The Illinois Department may by rule establish criteria for and develop methodologies for adjustment payments to hospitals participating under this Article.

(l) 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.

(m) The Department shall establish a cost-based reimbursement methodology for determining payments to hospitals for approved graduate medical education (GME) programs for dates of service on and after July 1, 2018.

(1) As used in this subsection, "hospitals" means the University of Illinois Hospital as defined in the University of Illinois Hospital Act and a county hospital

in a county of over 3,000,000 inhabitants.

(2) An amendment to the Illinois Title XIX State Plan defining GME shall maximize reimbursement, shall not be limited to the education programs or special patient care payments allowed under Medicare, and shall include:

(A) inpatient days;

(B) outpatient days;

(C) direct costs;

(D) indirect costs;

(E) managed care days;

(F) all stages of medical training and education including students, interns, residents, and fellows with no caps on the number of persons who may qualify; and

(G) patient care payments related to the complexities of treating Medicaid enrollees including clinical and social determinants of health.

(3) The Department shall make all GME payments directly to hospitals including such costs in support of clients enrolled in Medicaid managed care entities.

(4) The Department shall promptly take all actions necessary for reimbursement to be effective for dates of service on and after July 1, 2018 including publishing all appropriate public notices, amendments to the Illinois Title XIX State Plan, and adoption of administrative rules if necessary.

(5) As used in this subsection, "managed care days" means costs associated with services rendered to enrollees of Medicaid managed care entities. "Medicaid managed care entities" means any entity which contracts with the Department to provide services paid for on a capitated basis. "Medicaid managed care entities" includes a managed care organization and a managed care community network.

(6) All payments under this Section are contingent upon federal approval of changes to the Illinois Title XIX State Plan, if that approval is required.

(7) The Department may adopt rules necessary to implement Public Act 100-581 through the use of emergency rulemaking in accordance with subsection (aa) of Section 5-45 of the Illinois Administrative Procedure Act. For purposes of that Act, the General Assembly finds that the adoption of rules to implement Public Act 100-581 is deemed an emergency and necessary for the public interest, safety, and welfare.

(Source: P.A. 101-81, eff. 7-12-19; 102-682, eff. 12-10-21; 102-886, eff. 5-17-22.)

ARTICLE 85.

Section 85-5. The Illinois Act on the Aging is amended by changing Section 4.02 as follows:

(20 ILCS 105/4.02)

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

(a) (blank);

(b) (blank);

(c) home care aide services;

(d) personal assistant services;

(e) adult day services;

(f) home-delivered meals;

(g) education in self-care;

(h) personal care services;

(i) adult day health services;

(j) habilitation services;

(k) respite care;

(k-5) community reintegration services;

(k-6) flexible senior services;

(k-7) medication management;

(k-8) emergency home response;

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

(m) (blank).

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

The Department shall require as a condition of eligibility that all new financially eligible applicants apply for and enroll in medical assistance under Article V of the Illinois Public Aid Code in accordance with rules promulgated by the Department.

The Department shall, in conjunction with the Department of Public Aid (now Department of Healthcare and Family Services), seek appropriate amendments under Sections 1915 and 1924 of the Social Security Act. The purpose of the amendments shall be to extend eligibility for home and community based services under Sections 1915 and 1924 of the Social Security Act to persons who transfer to or for the benefit of a spouse those amounts of income and resources allowed under Section

1924 of the Social Security Act. Subject to the approval of such amendments, the Department shall extend the provisions of Section 5-4 of the Illinois Public Aid Code to persons who, but for the provision of home or community-based services, would require the level of care provided in an institution, as is provided for in federal law. Those persons no longer found to be eligible for receiving noninstitutional services due to changes in the eligibility criteria shall be given 45 days notice prior to actual termination. Those persons receiving notice of termination may contact the Department and request the determination be appealed at any time during the 45 day notice period. The target population identified for the purposes of this Section are persons age 60 and older with an identified service need. Priority shall be given to those who are at imminent risk of institutionalization. The services shall be provided to eligible persons age 60 and older to the extent that the cost of the services together with the other personal maintenance expenses of the persons are reasonably related to the standards established for care in a group facility appropriate to the person's condition. These noninstitutional services, pilot projects, or experimental facilities may be provided as part of or in addition to those authorized by federal law or those funded and administered by the Department of Human Services. The Departments of Human Services, Healthcare and Family Services, Public Health, Veterans' Affairs, and Commerce and Economic Opportunity and

other appropriate agencies of State, federal, and local governments shall cooperate with the Department on Aging in the establishment and development of the noninstitutional services. The Department shall require an annual audit from all personal assistant and home care aide vendors contracting with the Department under this Section. The annual audit shall assure that each audited vendor's procedures are in compliance with Department's financial reporting guidelines requiring an administrative and employee wage and benefits cost split as defined in administrative rules. The audit is a public record under the Freedom of Information Act. The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department of Healthcare and Family Services, to effect the following: (1) intake procedures and common eligibility criteria for those persons who are receiving noninstitutional services; and (2) the establishment and development of noninstitutional services in areas of the State where they are not currently available or are undeveloped. On and after July 1, 1996, all nursing home prescreenings for individuals 60 years of age or older shall be conducted by the Department.

As part of the Department on Aging's routine training of case managers and case manager supervisors, the Department may include information on family futures planning for persons who are age 60 or older and who are caregivers of their adult

children with developmental disabilities. The content of the training shall be at the Department's discretion.

The Department is authorized to establish a system of recipient copayment for services provided under this Section, such copayment to be based upon the recipient's ability to pay but in no case to exceed the actual cost of the services provided. Additionally, any portion of a person's income which is equal to or less than the federal poverty standard shall not be considered by the Department in determining the copayment. The level of such copayment shall be adjusted whenever necessary to reflect any change in the officially designated federal poverty standard.

The Department, or the Department's authorized representative, may recover the amount of moneys expended for services provided to or in behalf of a person under this Section by a claim against the person's estate or against the estate of the person's surviving spouse, but no recovery may be had until after the death of the surviving spouse, if any, and then only at such time when there is no surviving child who is under age 21 or blind or who has a permanent and total disability. This paragraph, however, shall not bar recovery, at the death of the person, of moneys for services provided to the person or in behalf of the person under this Section to which the person was not entitled; provided that such recovery shall not be enforced against any real estate while it is occupied as a homestead by the surviving spouse or other

dependent, if no claims by other creditors have been filed against the estate, or, if such claims have been filed, they remain dormant for failure of prosecution or failure of the claimant to compel administration of the estate for the purpose of payment. This paragraph shall not bar recovery from the estate of a spouse, under Sections 1915 and 1924 of the Social Security Act and Section 5-4 of the Illinois Public Aid Code, who precedes a person receiving services under this Section in death. All moneys for services paid to or in behalf of the person under this Section shall be claimed for recovery from the deceased spouse's estate. "Homestead", as used in this paragraph, means the dwelling house and contiguous real estate occupied by a surviving spouse or relative, as defined by the rules and regulations of the Department of Healthcare and Family Services, regardless of the value of the property.

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

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

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

to implement this item (2);

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

(4)(blank);

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

(A) bathing;

(B) grooming;

(C) toileting;

(D) nail care;

(E) transferring;

(F) respiratory services;

(G) exercise; or

(H) positioning;

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

(7) ensuring that the State may access maximum federal matching funds by seeking approval for the Centers for Medicare and Medicaid Services for modifications to the

State's home and community based services waiver and additional waiver opportunities, including applying for enrollment in the Balance Incentive Payment Program by May 1, 2013, in order to maximize federal matching funds; this shall include, but not be limited to, modification that reflects all changes in the Community Care Program services and all increases in the services cost maximum;

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

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

(10) working in conjunction with Care Coordination Units, the Department of Healthcare and Family Services, the Department of Human Services, Community Care Program providers, and other stakeholders to make improvements to the Medicaid claiming processes and the Medicaid enrollment procedures or requirements as needed, including, but not limited to, specific policy changes or

rules to improve the up-front enrollment of participants in the Medicaid program and specific policy changes or rules to ensure ~~insure~~ more prompt submission of bills to the federal government to secure maximum federal matching dollars as promptly as possible; the Department on Aging shall have at least 3 meetings with stakeholders by January 1, 2014 in order to address these improvements;

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

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

(13) (blank).

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

requirements. All applicants shall be subject to the provisions of the Health Care Worker Background Check Act.

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

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

certifications of in-service training completed to its ~~their~~ employees.

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

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

the Committee to represent provider, advocacy, policy research, and other constituencies committed to the delivery of high quality home and community-based services to older adults. Representatives shall be appointed to ensure representation from community care providers, including, but not limited to, adult day service providers, homemaker providers, case coordination and case management units, emergency home response providers, statewide trade or labor unions that represent home care aides and direct care staff, area agencies on aging, adults over age 60, membership organizations representing older adults, and other organizational entities, providers of care, or individuals with demonstrated interest and expertise in the field of home and community care as determined by the Director.

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

assistance and staff support to the committee. Department representation shall not constitute membership of the committee. All Committee papers, issues, recommendations, reports, and meeting memoranda are advisory only. The Director, or his or her designee, shall make a written report, as requested by the Committee, regarding issues before the Committee.

The Department on Aging and the Department of Human Services shall cooperate in the development and submission of an annual report on programs and services provided under this Section. Such joint report shall be filed with the Governor and the General Assembly on or before March 31 of the following fiscal year.

The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act and filing 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.

Those persons previously found eligible for receiving noninstitutional services whose services were discontinued under the Emergency Budget Act of Fiscal Year 1992, and who do not meet the eligibility standards in effect on or after July 1, 1992, shall remain ineligible on and after July 1, 1992. Those persons previously not required to cost-share and who were required to cost-share effective March 1, 1992, shall

continue to meet cost-share requirements on and after July 1, 1992. Beginning July 1, 1992, all clients will be required to meet eligibility, cost-share, and other requirements and will have services discontinued or altered when they fail to meet these requirements.

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

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

The Department shall require, as a condition of eligibility, application for the medical assistance program under Article V of the Illinois Public Aid Code.

The Department may authorize Community Care Program services until an applicant is determined eligible for medical assistance under Article V of the Illinois Public Aid Code.

The Department shall continue to provide Community Care Program reports as required by statute, which shall include an annual report on Care Coordination Unit performance and adherence to service guidelines and a 6-month supplemental report.

In regard to community care providers, failure to comply

with Department on Aging policies shall be cause for disciplinary action, including, but not limited to, disqualification from serving Community Care Program clients. Each provider, upon submission of any bill or invoice to the Department for payment for services rendered, shall include a notarized statement, under penalty of perjury pursuant to Section 1-109 of the Code of Civil Procedure, that the provider has complied with all Department policies.

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

The Department shall pay an enhanced rate of at least $1.77 per unit under the Community Care Program to those in-home service provider agencies that offer health insurance coverage as a benefit to their direct service worker employees pursuant to rules adopted by the Department. The Department shall review the enhanced rate as part of its process to rebase in-home service provider reimbursement rates pursuant to federal waiver requirements. Subject to federal approval, beginning on January 1, 2024, rates for adult day services shall be increased to $16.84 per hour and rates for each way transportation services for adult day services shall be increased to $12.44 per unit transportation.

Subject to federal approval, on and after January 1, 2024,

rates for homemaker services shall be increased to $28.07 to sustain a minimum wage of $17 per hour for direct service workers. Rates in subsequent State fiscal years shall be no lower than the rates put into effect upon federal approval. Providers of in-home services shall be required to certify to the Department that they remain in compliance with the mandated wage increase for direct service workers. Fringe benefits, including, but not limited to, paid time off and payment for training, health insurance, travel, or transportation, shall not be reduced in relation to the rate increases described in this paragraph.

Subject to and upon federal approval, on and after January 1, 2025, rates for homemaker services shall be increased to $29.63 to sustain a minimum wage of $18 per hour for direct service workers. Rates in subsequent State fiscal years shall be no lower than the rates put into effect upon federal approval. Providers of in-home services shall be required to certify to the Department that they remain in compliance with the mandated wage increase for direct service workers. Fringe benefits, including, but not limited to, paid time off and payment for training, health insurance, travel, or transportation, shall not be reduced in relation to the rate increases described in this paragraph.

Subject to and upon federal approval, on and after January 1, 2026, rates for homemaker services shall be increased to $30.80 to sustain a minimum wage of $18.75 per hour for direct

service workers. Rates in subsequent State fiscal years shall be no lower than the rates put into effect upon federal approval. Providers of in-home services shall be required to certify to the Department that they remain in compliance with the mandated wage increase for direct service workers. Fringe benefits, including, but not limited to, paid time off and payment for training, health insurance, travel, or transportation, shall not be reduced in relation to the rate increases described in this paragraph.

Beginning January 1, 2027, subject to any necessary federal approval, rates for adult day services shall be increased to $17.84 per hour and rates for each way transportation services for adult day services shall be increased to $13.44 per unit transportation.

The General Assembly finds it necessary to authorize an aggressive Medicaid enrollment initiative designed to maximize federal Medicaid funding for the Community Care Program which produces significant savings for the State of Illinois. The Department on Aging shall establish and implement a Community Care Program Medicaid Initiative. Under the Initiative, the Department on Aging shall, at a minimum: (i) provide an enhanced rate to adequately compensate care coordination units to enroll eligible Community Care Program clients into Medicaid; (ii) use recommendations from a stakeholder committee on how best to implement the Initiative; and (iii) establish requirements for State agencies to make enrollment

in the State's Medical Assistance program easier for seniors.

The Community Care Program Medicaid Enrollment Oversight Subcommittee is created as a subcommittee of the Older Adult Services Advisory Committee established in Section 35 of the Older Adult Services Act to make recommendations on how best to increase the number of medical assistance recipients who are enrolled in the Community Care Program. The Subcommittee shall consist of all of the following persons who must be appointed within 30 days after June 4, 2018 (the effective date of Public Act 100-587):

(1) The Director of Aging, or his or her designee, who shall serve as the chairperson of the Subcommittee.

(2) One representative of the Department of Healthcare and Family Services, appointed by the Director of Healthcare and Family Services.

(3) One representative of the Department of Human Services, appointed by the Secretary of Human Services.

(4) One individual representing a care coordination unit, appointed by the Director of Aging.

(5) One individual from a non-governmental statewide organization that advocates for seniors, appointed by the Director of Aging.

(6) One individual representing Area Agencies on Aging, appointed by the Director of Aging.

(7) One individual from a statewide association dedicated to Alzheimer's care, support, and research,

appointed by the Director of Aging.

(8) One individual from an organization that employs persons who provide services under the Community Care Program, appointed by the Director of Aging.

(9) One member of a trade or labor union representing persons who provide services under the Community Care Program, appointed by the Director of Aging.

(10) One member of the Senate, who shall serve as co-chairperson, appointed by the President of the Senate.

(11) One member of the Senate, who shall serve as co-chairperson, appointed by the Minority Leader of the Senate.

(12) One member of the House of Representatives, who shall serve as co-chairperson, appointed by the Speaker of the House of Representatives.

(13) One member of the House of Representatives, who shall serve as co-chairperson, appointed by the Minority Leader of the House of Representatives.

(14) One individual appointed by a labor organization representing frontline employees at the Department of Human Services.

The Subcommittee shall provide oversight to the Community Care Program Medicaid Initiative and shall meet quarterly. At each Subcommittee meeting the Department on Aging shall provide the following data sets to the Subcommittee: (A) the number of Illinois residents, categorized by planning and

service area, who are receiving services under the Community Care Program and are enrolled in the State's Medical Assistance Program; (B) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program, but are not enrolled in the State's Medical Assistance Program; and (C) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program and are eligible for benefits under the State's Medical Assistance Program, but are not enrolled in the State's Medical Assistance Program. In addition to this data, the Department on Aging shall provide the Subcommittee with plans on how the Department on Aging will reduce the number of Illinois residents who are not enrolled in the State's Medical Assistance Program but who are eligible for medical assistance benefits. The Department on Aging shall enroll in the State's Medical Assistance Program those Illinois residents who receive services under the Community Care Program and are eligible for medical assistance benefits but are not enrolled in the State's Medical ~~Medicaid~~ Assistance Program. The data provided to the Subcommittee shall be made available to the public via the Department on Aging's website.

The Department on Aging, with the involvement of the Subcommittee, shall collaborate with the Department of Human Services and the Department of Healthcare and Family Services on how best to achieve the responsibilities of the Community

Care Program Medicaid Initiative.

The Department on Aging, the Department of Human Services, and the Department of Healthcare and Family Services shall coordinate and implement a streamlined process for seniors to access benefits under the State's Medical Assistance Program.

The Subcommittee shall collaborate with the Department of Human Services on the adoption of a uniform application submission process. The Department of Human Services and any other State agency involved with processing the medical assistance application of any person enrolled in the Community Care Program shall include the appropriate care coordination unit in all communications related to the determination or status of the application.

The Community Care Program Medicaid Initiative shall provide targeted funding to care coordination units to help seniors complete their applications for medical assistance benefits. On and after July 1, 2019, care coordination units shall receive no less than $200 per completed application, which rate may be included in a bundled rate for initial intake services when Medicaid application assistance is provided in conjunction with the initial intake process for new program participants.

The Community Care Program Medicaid Initiative shall cease operation 5 years after June 4, 2018 (the effective date of Public Act 100-587), after which the Subcommittee shall dissolve.

Effective July 1, 2023, subject to federal approval, the Department on Aging shall reimburse Care Coordination Units at the following rates for case management services: $252.40 for each initial assessment; $366.40 for each initial assessment with translation; $229.68 for each redetermination assessment; $313.68 for each redetermination assessment with translation; $200.00 for each completed application for medical assistance benefits; $132.26 for each face-to-face, choices-for-care screening; $168.26 for each face-to-face, choices-for-care screening with translation; $124.56 for each 6-month, face-to-face visit; $132.00 for each MCO participant eligibility determination; and $157.00 for each MCO participant eligibility determination with translation.

(Source: P.A. 103-8, eff. 6-7-23; 103-102, Article 45, Section 45-5, eff. 1-1-24; 103-102, Article 85, Section 85-5, eff. 1-1-24; 103-102, Article 90, Section 90-5, eff. 1-1-24; 103-588, eff. 6-5-24; 103-605, eff. 7-1-24; 103-670, eff. 1-1-25; 104-2, eff. 6-16-25; 104-417, eff. 8-15-25.)

ARTICLE 145.

Section 145-5. The Illinois Public Aid Code is amended by changing Section 14-12.5 as follows:

(305 ILCS 5/14-12.5)

Sec. 14-12.5. Hospital rate updates.

(a) Notwithstanding any other provision of this Code, the hospital rates of reimbursement authorized under Sections 5-5.05, 14-12, and 14-13 of this Code shall be adjusted in accordance with the provisions of this Section.

(b) Notwithstanding any other provision of this Code, effective for dates of service on and after January 1, 2024, subject to federal approval, hospital reimbursement rates shall be revised as follows:

(1) For inpatient general acute care services, the statewide-standardized amount and the per diem rates for hospitals exempt from the APR-DRG reimbursement system, in effect January 1, 2023, shall be increased by 10%.

(2) For inpatient psychiatric services:

(A) For safety-net hospitals, the hospital specific per diem rate in effect January 1, 2023 and the minimum per diem rate of $630, authorized in subsection (b-5) of Section 5-5.05 of this Code, shall be increased by 10%.

(B) For all general acute care hospitals that are not safety-net hospitals, the inpatient psychiatric care per diem rates in effect January 1, 2023 shall be increased by 10%, except that all rates shall be at least 90% of the minimum inpatient psychiatric care per diem rate for safety-net hospitals as authorized in subsection (b-5) of Section 5-5.05 of this Code including the adjustments authorized in this Section.

The statewide default per diem rate for a hospital opening a new psychiatric distinct part unit, shall be set at 90% of the minimum inpatient psychiatric care per diem rate for safety-net hospitals as authorized in subsection (b-5) of Section 5-5.05 of this Code, including the adjustment authorized in this Section.

(C) For all psychiatric specialty hospitals, the per diem rates in effect January 1, 2023, shall be increased by 10%, except that all rates shall be at least 90% of the minimum inpatient per diem rate for safety-net hospitals as authorized in subsection (b-5) of Section 5-5.05 of this Code, including the adjustments authorized in this Section. The statewide default per diem rate for a new psychiatric specialty hospital shall be set at 90% of the minimum inpatient psychiatric care per diem rate for safety-net hospitals as authorized in subsection (b-5) of Section 5-5.05 of this Code, including the adjustment authorized in this Section.

(3) For inpatient rehabilitative services, all hospital specific per diem rates in effect January 1, 2023, shall be increased by 10%. The statewide default inpatient rehabilitative services per diem rates, for general acute care hospitals and for rehabilitation specialty hospitals respectively, shall be increased by 10%.

(4) The statewide-standardized amount for outpatient general acute care services in effect January 1, 2023, shall be increased by 10%.

(5) The statewide-standardized amount for outpatient psychiatric care services in effect January 1, 2023, shall be increased by 10%.

(6) The statewide-standardized amount for outpatient rehabilitative care services in effect January 1, 2023, shall be increased by 10%.

(7) The per diem rate in effect January 1, 2023, as authorized in subsection (a) of Section 14-13 of this Article shall be increased by 10%.

(8) For services provided on and after January 1, 2024 through June 30, 2024, and on and after January 1, 2029 ~~2027~~, subject to federal approval, in addition to the statewide standardized amount, an add-on payment of at least $210 shall be paid for each inpatient General Acute and Psychiatric day of care, excluding Medicare-Medicaid dual eligible crossover days, for all safety-net hospitals defined in Section 5-5e.1 of this Code.

(A) For Psychiatric days of care, the Department may implement payment of this add-on by increasing the hospital specific psychiatric per diem rate, adjusted in accordance with subparagraph (A) of paragraph (2) of subsection (b) by $210, or by a separate add-on payment.

(B) If the add-on adjustment is added to the hospital specific psychiatric per diem rate to operationalize payment, the Department shall provide a rate sheet to each safety-net hospital, which identifies the hospital psychiatric per diem rate before and after the adjustment.

(C) The add-on adjustment shall not be considered when setting the 90% minimum rate identified in paragraph (2) of subsection (b).

(9) For services provided on and after July 1, 2024, and on or before December 31, 2028 ~~2026~~, subject to federal approval, in addition to the statewide standardized amount and any other payments authorized under this Code, a safety-net hospital health care equity add-on payment shall be paid for each inpatient General Acute and Psychiatric day of care, excluding Medicare-Medicaid dual eligible crossover days, for safety-net hospitals defined in Section 5-5e.1 of this Code, as follows:

(A) if the safety-net hospital's Medicaid inpatient utilization rate, as calculated under Section 5-5e.1 of this Code, is equal to or greater than 70%, the add-on payment shall be $425;

(B) if the safety-net hospital's Medicaid inpatient utilization rate, as calculated under Section 5-5e.1 of this Code, is equal to or greater

than 50% and less than 70%, the add-on payment shall be $300;

(C) if the safety-net hospital's Medicaid inpatient utilization rate, as calculated under Section 5-5e.1 of this Code, is equal to or greater than 40% and less than 50%, the add-on payment shall be $225; and

(D) if the safety-net hospital's Medicaid inpatient utilization rate, as calculated under Section 5-5e.1 of this Code, is less than 40%, the add-on payment shall be $210.

Qualification for the safety-net hospital health care equity add-on payment shall be updated January 1, 2026, and each January 1 thereafter based on the MIUR determination effective 3 months prior to the start of each ~~the January 1, 2026~~ calendar year, ending in 2028.

Rates described in subparagraphs (A) through (C) shall be adjusted annually beginning January 1, 2026 by applying a uniform factor to each rate to spend an approximate amount of $50,000,000 annually per year using State fiscal year 2024 days as a basis for calendar year 2026 rates.

The add-on adjustment under this paragraph shall not be considered when setting the 90% minimum rate identified in subparagraph (B) of paragraph (2).

(10) For services provided on and after July 1, 2024, and on or before December 31, 2028 ~~2026~~, subject to

federal approval, in addition to the statewide standardized amount and any other payments authorized under this Code, a safety-net hospital low volume add-on payment of the lesser of $200 or the annually recalculated amount described below shall be paid for each inpatient General Acute and Psychiatric day of care, excluding Medicare-Medicaid dual eligible crossover days, for any safety-net hospital as defined in Section 5-5e.1 that provided less than 11,000 Medicaid inpatient days of care, excluding Medicare-Medicaid dual eligible crossover days, in the base period. As used in this paragraph, "base period" means State fiscal year 2022 admissions received by the Department prior to October 1, 2023 for the payment period July 1, 2024 through December 31, 2025, and beginning in calendar year 2026, the State fiscal year that ends 30 months before the applicable calendar year, such as State fiscal year 2023 admissions received by the Department prior to October 1, 2024, for calendar year 2026. The low volume add-on payment amount of $200 shall be adjusted annually beginning January 1, 2027 if projected overall payment exceeds $30,000,000 by setting a rate to spend an approximate amount of $30,000,000 annually using the most recent complete State fiscal year inpatient General Acute and Psychiatric day of care data, excluding Medicare-Medicaid dual eligible crossover days for qualifying hospitals. State Fiscal Year 2025 data

shall be used as the basis for the Calendar Year 2027 rate, and State Fiscal Year 2026 data shall be used as the basis for the Calendar Year 2028 rate.

(c) The Department shall take all actions necessary to ensure the changes authorized in Public Act 103-102 and this amendatory Act of the 103rd General Assembly are in effect for dates of service on and after the effective date of the changes made to this Section by this amendatory Act of the 103rd General Assembly, including publishing all appropriate public notices, applying for federal approval of amendments to the Illinois Title XIX State Plan, and adopting administrative rules if necessary.

(d) The Department of Healthcare and Family Services may adopt rules necessary to implement the changes made by Public Act 103-102 and this amendatory Act of the 103rd General Assembly through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this Section. The General Assembly finds that the adoption of rules to implement the changes made by Public Act 103-102 and this amendatory Act of the 103rd General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare.

(e) The Department shall ensure that all necessary adjustments to the managed care organization capitation base rates necessitated by the adjustments in this Section are

completed, published, and applied in accordance with Section 5-30.8 of this Code 90 days prior to the implementation date of the changes required under Public Act 103-102 and this amendatory Act of the 103rd General Assembly.

(f) The Department shall publish updated rate sheets or add-on payment amounts, as applicable, for all hospitals 30 days prior to the effective date of the rate increase, or within 30 days after federal approval by the Centers for Medicare and Medicaid Services, whichever is later.

(Source: P.A. 103-102, eff. 6-16-23; 103-593, eff. 6-7-24.)

ARTICLE 175.

Section 175-5. The Illinois Public Aid Code is amended by changing Section 5-30.1 as follows:

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

"Managed care organization" or "MCO" means any entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

"Emergency services" means health care items and services, including inpatient and outpatient hospital services, furnished or required to evaluate and stabilize an emergency medical condition. "Emergency services" include inpatient

stabilization services furnished during the inpatient stabilization period. "Emergency services" do not include post-stabilization medical services.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, regardless of the final diagnosis given, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) 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;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) inadequately controlled pain; or

(5) with respect to a pregnant woman who is having contractions:

(A) inadequate time to complete a safe transfer to another hospital before delivery; or

(B) a transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

"Emergency medical screening examination" means a medical screening examination and evaluation by a physician licensed to practice medicine in all its branches or, to the extent permitted by applicable laws, by other appropriately licensed

personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches to determine whether the need for emergency services exists.

"Health care services" means ~~mean~~ any medical or behavioral health services covered under the medical assistance program that are subject to review under a service authorization program.

"Inpatient stabilization period" means the initial 72 hours of inpatient stabilization services, beginning from the date and time of the order for inpatient admission to the hospital.

"Inpatient stabilization services" means ~~mean~~ emergency services furnished in the inpatient setting at a hospital pursuant to an order for inpatient admission by a physician or other qualified practitioner who has admitting privileges at the hospital, as permitted by State law, to stabilize an emergency medical condition following an emergency medical screening examination.

"Post-stabilization medical services" means health care services provided to an enrollee that are furnished in a hospital by a provider that is qualified to furnish such services and determined to be medically necessary by the provider and directly related to the emergency medical condition following stabilization.

"Provider" means a facility or individual who is actively enrolled in the medical assistance program and licensed or

otherwise authorized to order, prescribe, refer, or render health care services in this State.

"Service authorization determination" means a decision made by a service authorization program in advance of, concurrent to, or after the provision of a health care service to approve, change the level of care, partially deny, deny, or otherwise limit coverage and reimbursement for a health care service upon review of a service authorization request.

"Service authorization program" means any utilization review, utilization management, peer review, quality review, or other medical management activity conducted by an MCO, or its contracted utilization review organization, including, but not limited to, prior authorization, prior approval, pre-certification, concurrent review, retrospective review, or certification of admission, of health care services provided in the inpatient or outpatient hospital setting.

"Service authorization request" means a request by a provider to a service authorization program to determine whether a health care service meets the reimbursement eligibility requirements for medically necessary, clinically appropriate care, resulting in the issuance of a service authorization determination.

"Utilization review organization" or "URO" means an MCO's utilization review department or a peer review organization or quality improvement organization that contracts with an MCO to administer a service authorization program and make service

authorization determinations.

(b) As provided by Section 5-16.12, managed care organizations are subject to the provisions of the Managed Care Reform and Patient Rights Act.

(c) An MCO shall pay any provider of emergency services, including for inpatient stabilization services provided during the inpatient stabilization period, that does not have in effect a contract with the contracted Medicaid MCO. The default rate of reimbursement shall be the rate paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates.

(d) (Blank).

(e) Notwithstanding any other provision of law, the following requirements apply to MCOs in determining payment for all emergency services, including inpatient stabilization services provided during the inpatient stabilization period:

(1) The MCO shall not impose any service authorization program requirements for emergency services, including, but not limited to, prior authorization, prior approval, pre-certification, certification of admission, concurrent review, or retrospective review.

(A) Notification period: Hospitals shall notify the enrollee's Medicaid MCO within 48 hours of the date and time the order for inpatient admission is written. Notification shall be limited to advising the MCO that the patient has been admitted to a hospital inpatient level of care.

(B) If the admitting hospital complies with the notification provisions of subparagraph (A), the Medicaid MCO may not initiate concurrent review before the end of the inpatient stabilization period. If the admitting hospital does not comply with the notification requirements in subparagraph (A), the Medicaid MCO may initiate concurrent review for the continuation of the stay beginning at the end of the 48-hour notification period.

(C) Coverage for services provided during the 48-hour notification period may not be retrospectively denied.

(2) The MCO shall cover emergency services provided to enrollees who are temporarily away from their residence and outside the contracting area to the extent that the enrollees would be entitled to the emergency services if they still were within the contracting area.

(3) The MCO shall have no obligation to cover emergency services provided on an emergency basis that are not covered services under the contract between the MCO

and the Department.

(4) The MCO shall not condition coverage for emergency services on the treating provider notifying the MCO of the enrollee's emergency medical screening examination and treatment within 10 days after presentation for emergency services.

(5) The determination of the attending emergency physician, or the practitioner responsible for the enrollee's care at the hospital, of whether an enrollee requires inpatient stabilization services, can be stabilized in the outpatient setting, or is sufficiently stabilized for discharge or transfer to another setting, shall be binding on the MCO. The MCO shall cover and reimburse providers for emergency services as billed by the provider for all enrollees whether the emergency services are provided by an affiliated or non-affiliated provider, except in cases of fraud. The MCO shall reimburse inpatient stabilization services provided during the inpatient stabilization period and billed as inpatient level of care based on the appropriate inpatient reimbursement methodology.

(6) The MCO's financial responsibility for post-stabilization medical services it has not pre-approved ends when:

(A) a plan physician with privileges at the treating hospital assumes responsibility for the

enrollee's care;

(B) a plan physician assumes responsibility for the enrollee's care through transfer;

(C) a contracting entity representative and the treating physician reach an agreement concerning the enrollee's care; or

(D) the enrollee is discharged.

(e-5) An MCO shall pay for all post-stabilization medical services as a covered service in any of the following situations:

(1) the MCO or its URO authorized such services;

(2) such services were administered to maintain the enrollee's stabilized condition within one hour after a request to the MCO for authorization of further post-stabilization services;

(3) the MCO or its URO did not respond to a request to authorize such services within one hour;

(4) the MCO or its URO could not be contacted; or

(5) the MCO or its URO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an agreement concerning the enrollee's care and an affiliated provider was unavailable for a consultation, in which case the MCO must pay for such services rendered by the treating non-affiliated provider until an affiliated provider was reached and either concurred with the treating non-affiliated provider's plan of care or

assumed responsibility for the enrollee's care. Such payment shall be made at the default rate of reimbursement paid under the State's Medicaid fee-for-service program methodology, including all policy adjusters, including, but not limited to, Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent that such adjustments are incorporated in the development of the applicable MCO capitated rates.

(f) Network adequacy and transparency.

(1) The Department shall:

(A) ensure that an adequate provider network is in place, taking into consideration health professional shortage areas and medically underserved areas;

(B) publicly release an explanation of its process for analyzing network adequacy;

(C) periodically ensure that an MCO continues to have an adequate network in place;

(D) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet provider directory requirements under Section 5-30.3;

(E) require MCOs to ensure that any Medicaid-certified provider under contract with an MCO and previously submitted on a roster on the date of service is paid for any medically necessary, Medicaid-covered, and authorized service rendered to

any of the MCO's enrollees, regardless of inclusion on the MCO's published and publicly available directory of available providers; and

(F) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet each of the requirements under subsection (d-5) of Section 10 of the Network Adequacy and Transparency Act; with necessary exceptions to the MCO's network to ensure that admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in paragraph (3) of subsection (d-5) of Section 10 of the Network Adequacy and Transparency Act is limited to providers or facilities that are Medicaid certified.

(2) Each MCO shall confirm its receipt of information submitted specific to physician or dentist additions or physician or dentist deletions from the MCO's provider network within 3 days after receiving all required information from contracted physicians or dentists, and electronic physician and dental directories must be updated consistent with current rules as published by the Centers for Medicare and Medicaid Services or its successor agency.

(g) Timely payment of claims.

(1) The MCO shall pay a claim within 30 days of receiving a claim that contains all the essential

information needed to adjudicate the claim.

(2) The MCO shall notify the billing party of its inability to adjudicate a claim within 30 days of receiving that claim.

(3) The MCO shall pay a penalty that is at least equal to the timely payment interest penalty imposed under Section 368a of the Illinois Insurance Code for any claims not timely paid.

(A) When an MCO is required to pay a timely payment interest penalty to a provider, the MCO must calculate and pay the timely payment interest penalty that is due to the provider within 30 days after the payment of the claim. In no event shall a provider be required to request or apply for payment of any owed timely payment interest penalties.

(B) Such payments shall be reported separately from the claim payment for services rendered to the MCO's enrollee and clearly identified as interest payments.

(4)(A) The Department shall require MCOs to expedite payments to providers identified on the Department's expedited provider list, determined in accordance with 89 Ill. Adm. Code 140.71(b), on a schedule at least as frequently as the providers are paid under the Department's fee-for-service expedited provider schedule.

(B) Compliance with the expedited provider requirement

may be satisfied by an MCO through the use of a Periodic Interim Payment (PIP) program that has been mutually agreed to and documented between the MCO and the provider, if the PIP program ensures that any expedited provider receives regular and periodic payments based on prior period payment experience from that MCO. Total payments under the PIP program may be reconciled against future PIP payments on a schedule mutually agreed to between the MCO and the provider.

(C) The Department shall share at least monthly its expedited provider list and the frequency with which it pays providers on the expedited list.

(g-5) Recognizing that the rapid transformation of the Illinois Medicaid program may have unintended operational challenges for both payers and providers:

(1) in no instance shall a medically necessary covered service rendered in good faith, based upon eligibility information documented by the provider, be denied coverage or diminished in payment amount if the eligibility or coverage information available at the time the service was rendered is later found to be inaccurate in the assignment of coverage responsibility between MCOs or the fee-for-service system, except for instances when an individual is deemed to have not been eligible for coverage under the Illinois Medicaid program; and

(2) the Department shall, by December 31, 2016, adopt

rules establishing policies that shall be included in the Medicaid managed care policy and procedures manual addressing payment resolutions in situations in which a provider renders services based upon information obtained after verifying a patient's eligibility and coverage plan through either the Department's current enrollment system or a system operated by the coverage plan identified by the patient presenting for services:

(A) such medically necessary covered services shall be considered rendered in good faith;

(B) such policies and procedures shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the identified provider industry; and

(C) such rules shall be published for a review and comment period of no less than 30 days on the Department's website with final rules remaining available on the Department's website.

The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service,

fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

The rules shall be applicable for both MCO coverage and fee-for-service coverage.

If the fee-for-service system is ultimately determined to have been responsible for coverage on the date of service, the Department shall provide for an extended period for claims submission outside the standard timely filing requirements.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of metrics:

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

(2) The Department shall ensure that the metrics report is accessible to providers online by January 1, 2017.

(3) The metrics shall be developed in consultation

with industry representatives of the Medicaid managed care health plans and representatives of associations representing the majority of providers within the identified industry.

(4) Metrics shall be defined and incorporated into the applicable Managed Care Policy Manual issued by the Department.

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to Public Act 100-580, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims.

(g-8) Dispute resolution process. The Department shall maintain a provider complaint portal through which a provider can submit to the Department unresolved disputes with an MCO. An unresolved dispute means an MCO's decision that denies in whole or in part a claim for reimbursement to a provider for health care services rendered by the provider to an enrollee of the MCO with which the provider disagrees. Disputes shall not be submitted to the portal until the provider has availed

itself of the MCO's internal dispute resolution process. Disputes that are submitted to the MCO internal dispute resolution process may be submitted to the Department of Healthcare and Family Services' complaint portal no sooner than 30 days after submitting to the MCO's internal process and not later than 30 days after the unsatisfactory resolution of the internal MCO process or 60 days after submitting the dispute to the MCO internal process. Multiple claim disputes involving the same MCO may be submitted in one complaint, regardless of whether the claims are for different enrollees, when the specific reason for non-payment of the claims involves a common question of fact or policy. Within 10 business days of receipt of a complaint, the Department shall present such disputes to the appropriate MCO, which shall then have 30 days to issue its written proposal to resolve the dispute. The Department may grant one 30-day extension of this time frame to one of the parties to resolve the dispute. If the dispute remains unresolved at the end of this time frame or the provider is not satisfied with the MCO's written proposal to resolve the dispute, the provider may, within 30 days, request the Department to review the dispute and make a final determination. Within 30 days of the request for Department review of the dispute, both the provider and the MCO shall present all relevant information to the Department for resolution and make individuals with knowledge of the issues available to the Department for further inquiry if needed.

Within 30 days of receiving the relevant information on the dispute, or the lapse of the period for submitting such information, the Department shall issue a written decision on the dispute based on contractual terms between the provider and the MCO, contractual terms between the MCO and the Department of Healthcare and Family Services and applicable Medicaid policy. The decision of the Department shall be final. By January 1, 2020, the Department shall establish by rule further details of this dispute resolution process. Disputes between MCOs and providers presented to the Department for resolution are not contested cases, as defined in Section 1-30 of the Illinois Administrative Procedure Act, conferring any right to an administrative hearing.

(g-9)(1) The Department shall publish annually on its website a report on the calculation of each managed care organization's medical loss ratio showing the following:

(A) Premium revenue, with appropriate adjustments.

(B) Benefit expense, setting forth the aggregate amount spent for the following:

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

(iv) Direct reserves.

(v) Gross recoveries.

(vi) Expenses for activities that improve health care quality as allowed by the Department.

(2) The medical loss ratio shall be calculated consistent with federal law and regulation following a claims runout period determined by the Department.

(g-10)(1) "Liability effective date" means the date on which an MCO becomes responsible for payment for medically necessary and covered services rendered by a provider to one of its enrollees in accordance with the contract terms between the MCO and the provider. The liability effective date shall be the later of:

(A) The execution date of a network participation contract agreement.

(B) The date the provider or its representative submits to the MCO the complete and accurate standardized roster form for the provider in the format approved by the Department.

(C) The provider effective date contained within the Department's provider enrollment subsystem within the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) System.

(2) The standardized roster form may be submitted to the MCO at the same time that the provider submits an enrollment application to the Department through IMPACT.

(3) By October 1, 2019, the Department shall require all MCOs to update their provider directory with information for new practitioners of existing contracted providers within 30 days of receipt of a complete and accurate standardized roster

template in the format approved by the Department provided that the provider is effective in the Department's provider enrollment subsystem within the IMPACT system. Such provider directory shall be readily accessible for purposes of selecting an approved health care provider and comply with all other federal and State requirements.

(g-11) The Department shall work with relevant stakeholders on the development of operational guidelines to enhance and improve operational performance of Illinois' Medicaid managed care program, including, but not limited to, improving provider billing practices, reducing claim rejections and inappropriate payment denials, and standardizing processes, procedures, definitions, and response timelines, with the goal of reducing provider and MCO administrative burdens and conflict. The Department shall include a report on the progress of these program improvements and other topics in its Fiscal Year 2020 annual report to the General Assembly.

(g-12) Notwithstanding any other provision of law, if the Department or an MCO requires submission of a claim for payment in a non-electronic format, a provider shall always be afforded a period of no less than 90 business days, as a correction period, following any notification of rejection by either the Department or the MCO to correct errors or omissions in the original submission.

Under no circumstances, either by an MCO or under the

State's fee-for-service system, shall a provider be denied payment for failure to comply with any timely submission requirements under this Code or under any existing contract, unless the non-electronic format claim submission occurs after the initial 180 days following the latest date of service on the claim, or after the 90 business days correction period following notification to the provider of rejection or denial of payment.

(g-13) Utilization Review Standardization and Transparency.

(1) To ensure greater standardization and transparency related to service authorization determinations, for all individuals covered under the medical assistance program and enrolled in the managed care program ~~, including both the fee-for-service and managed care programs,~~ the Department shall, in consultation with the MCOs, a statewide association representing the MCOs, a statewide association representing the majority of Illinois hospitals, a statewide association representing physicians, or any other interested parties deemed appropriate by the Department, adopt administrative rules consistent with this subsection, in accordance with the Illinois Administrative Procedure Act.

(2) No later than July 1, 2025, the Department shall in accordance with the Illinois Administrative Procedure Act file emergency rules, and adopt permanent rules no

later than November 28, 2025 ~~October 1, 2025~~, which govern MCO practices for dates of services on and after July 1, 2025, as follows:

(A) guidelines related to the publication of MCO service authorization policies;

(B) procedures listed on the Medicare Inpatient Only list published on January 1, 2025 by the Centers for Medicare and Medicaid Services in Addendum B to CMS-1809-FC that, due to medical complexity, must be reimbursed under the applicable inpatient methodology, when provided in the inpatient setting and billed as an inpatient service;

(C) standardization of administrative forms used in the member appeal process;

(D) limitations on second or subsequent medical necessity review of a health care service already authorized by the MCO or URO under a service authorization program;

(E) standardization of peer-to-peer processes and timelines;

(F) defined criteria for urgent and standard post-acute care and long-term acute care service authorization requests; and

(G) standardized criteria for service authorization programs for authorization of admission to a long-term acute care hospital.

(3) The Department shall expand the scope of the quality and compliance audits conducted by its contracted external quality review organization to include, but not be limited to:

(A) an analysis of the Medicaid MCO's compliance with nationally recognized clinical decision guidelines for inpatient and outpatient hospital services;

(B) an analysis that compares and contrasts the Medicaid MCO's service authorization determination outcomes for inpatient and outpatient hospital services to the outcomes of each other MCO plan and the State's fee-for-service program model to evaluate whether service authorization determinations are being made consistently by all Medicaid MCOs to ensure that all individuals are being treated in accordance with equitable standards of care;

(C) an analysis, for each Medicaid MCO, of the number of service authorization requests, including requests for concurrent review of inpatient hospital admissions and certification of inpatient hospital admissions, received, initially denied, overturned through any post-denial process including, but not limited to, enrollee or provider appeal, peer-to-peer review, or the provider dispute resolution process, denied but approved for a lower or different level of

care, and the number denied on final determination; and

(D) provide a written report to the General Assembly, detailing the items listed in this subsection and any other metrics deemed necessary by the Department, by the second April, following June 7, 2025 ~~2024 (the effective date of Public Act 103-593)~~, and each April thereafter. The Department shall make this report available within 30 days of delivery to the General Assembly, on its public facing website.

(h) The Department shall not expand mandatory MCO enrollment into new counties beyond those counties already designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(h-5) Leading indicator data sharing. By January 1, 2024, the Department shall obtain input from the Department of Human Services, the Department of Juvenile Justice, the Department of Children and Family Services, the State Board of Education, managed care organizations, providers, and clinical experts to identify and analyze key indicators and data elements that can be used in an analysis of lead indicators from assessments and data sets available to the Department that can be shared with

managed care organizations and similar care coordination entities contracted with the Department as leading indicators for elevated behavioral health crisis risk for children, including data sets such as the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS), calls made to the State's Crisis and Referral Entry Services (CARES) hotline, health services information from Health and Human Services Innovators, or other data sets that may include key indicators. The workgroup shall complete its recommendations for leading indicator data elements on or before September 1, 2024. To the extent permitted by State and federal law, the identified leading indicators shall be shared with managed care organizations and similar care coordination entities contracted with the Department on or before December 1, 2024 for the purpose of improving care coordination with the early detection of elevated risk. Leading indicators shall be reassessed annually with stakeholder input. The Department shall implement guidance to managed care organizations and similar care coordination entities contracted with the Department, so that the managed care organizations and care coordination entities respond to lead indicators with services and interventions that are designed to help stabilize the child.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after June 16, 2014 (the effective date of Public

Act 98-651).

(j) Health care information released to managed care organizations. A health care provider shall release to a Medicaid managed care organization, upon request, and subject to the Health Insurance Portability and Accountability Act of 1996 and any other law applicable to the release of health information, the health care information of the MCO's enrollee, if the enrollee has completed and signed a general release form that grants to the health care provider permission to release the recipient's health care information to the recipient's insurance carrier.

(k) The Department of Healthcare and Family Services, managed care organizations, a statewide organization representing hospitals, and a statewide organization representing safety-net hospitals shall explore ways to support billing departments in safety-net hospitals.

(l) The requirements of this Section added by Public Act 102-4 shall apply to services provided on or after the first day of the month that begins 60 days after April 27, 2021 (the effective date of Public Act 102-4).

(m) Except where otherwise expressly specified, the requirements of this Section added by Public Act 103-593 shall apply to services provided on and after July 1, 2026.

(Source: P.A. 103-546, eff. 8-11-23; 103-593, eff. 6-7-24; 103-885, eff. 8-9-24; 104-9, eff. 6-16-25; 104-417, eff. 8-15-25.)

ARTICLE 180.

Section 180-5. The Psychiatric Residential Treatment Facilities (PRTF) Act is amended by changing Sections 10 and 15 as follows:

(405 ILCS 142/10)

Sec. 10. PRTF services.

(a) The Department shall establish an Illinois Psychiatric Residential Treatment Facilities (PRTF) program that is family-driven, youth-guided, and trauma-informed, and includes youth and family involvement in all aspects of care planning. The Illinois PRTF program design shall establish meaningful opportunities for youth and families to be involved in the design, monitoring, and oversight of PRTF services.

(b) By September 1, 2027 ~~By January 1, 2026~~, the Department shall submit a State Plan Amendment to the Centers for Medicare and Medicaid Services to establish coverage of federally authorized, medically necessary inpatient psychiatric services delivered by a certified PRTF to medical assistance beneficiaries under 21 years of age.

(c) The Department shall adopt rules to implement the Illinois PRTF program. The rules may establish the services, standards, and requirements for participation in the program to comply with all applicable federal statutes, regulations,

requirements, and policies. The rules proposed by the Department may take into consideration the recommendations of the PRTF Advisory Committee, as outlined in Section 20. At a minimum, the rules shall include the following:

(1) Certification and participation requirements for PRTF providers in compliance with all applicable federal laws, regulations, requirements, and policies, including those found at 42 CFR 441, Subpart D and 42 CFR 483, Subpart G or any successor regulations.

(2) Monitoring and oversight of PRTF services, including on-site review protocols that include scheduled and unannounced on-site visits. Each provider seeking PRTF certification shall minimally have an on-site review prior to initiating services and all PRTFs shall have at least one on-site review annually thereafter.

(3) Utilization management criteria to ensure that PRTF services are provided as medically necessary and emphasize clinically appropriate patient transitions back to the community, including, but not limited to, service authorization, documentation, and treatment plan requirements for initial stay reviews and continued stay reviews.

(4) A limit on allowable beds at any one PRTF, not to exceed 40 total beds, unless waived in writing by the Director of the Department.

(5) A limit on the number of new PRTF facilities to be

certified in any State fiscal year.

(6) A requirement that PRTFs are distinct, standalone non-hospital entities not physically attached or adjacent to any other type of facility engaged in providing congregate care.

(7) A requirement that, in order to obtain PRTF certification, providers must undergo a survey from the State Survey Agency, the Department of Public Health, to establish the provider's compliance with the Conditions of Participation for PRTFs outlined in 42 CFR 483, Subpart G and the Interpretive Guidelines issued by the Centers for Medicare and Medicaid Services.

(8) A requirement that, in order to obtain PRTF certification, providers be accredited from one of the following organizations identified in 42 CFR 441.151, or any successor regulations:

(i) Joint Commission on Accreditation of Healthcare Organizations.

(ii) The Commission on Accreditation of Rehabilitation Facilities.

(iii) The Council on Accreditation of Services for Families and Children.

(iv) Any other accrediting organization with comparable standards recognized by the Department.

(9) Requirements for the reporting of emergency safety interventions and serious occurrences to the Department

and the State-designated Protection and Advocacy System no later than the close of business the next business day after the intervention or occurrence.

(Source: P.A. 104-147, eff. 8-1-25.)

(405 ILCS 142/15)

Sec. 15. PRTF capacity analysis.

(a) The Department shall establish, and update as needed, a methodology for completing a statewide PRTF capacity analysis for the purposes of identifying capacity needs for PRTF services under the Illinois Medical Assistance Program. The Department shall utilize the PRTF capacity analysis to inform its certification and enrollment of PRTF providers. The capacity analysis shall minimally include:

(1) An analysis of aggregate service utilization data for Medicaid eligible individuals under the age of 21, including community-based services, behavioral health crisis services, and inpatient psychiatric hospitalization services.

(2) Identification of locations across the State with demonstrated need for PRTF services and locations with demonstrated surplus of PRTF service capacity.

(3) Consideration of specialized treatment needs based on increased utilization of out-of-state facilities to address specialized treatment needs.

(4) Other factors of consideration identified by the

Department as necessary to support access to care, compliance with the federal Medicaid program, and all other applicable federal or State laws, regulations, policies, requirements, and programs impacting Illinois' children's behavioral health service delivery system.

(5) Recommendations to the Department and the PRTF Advisory Committee on capacity needs within the Illinois PRTF program. The recommendations shall seek to avoid the concentration of PRTF facilities in any particular community or area of the State to promote access for families or guardians to visit patients when appropriate.

(b) The Department's methodology, completed analyses, and outcomes shall be published on its website, with an initial PRTF capacity analysis to be published by no later than April 1, 2027 ~~January 1, 2026~~.

(c) The Department's PRTF capacity analysis shall be updated at a minimum of every 5 years and shall be performed consistent with the Department's published methodology.

(Source: P.A. 104-147, eff. 8-1-25.)

ARTICLE 185.

Section 185-5. The Illinois Public Aid Code is amended by changing Section 1-8.5 as follows:

(305 ILCS 5/1-8.5)

Sec. 1-8.5. Eligibility for medical assistance during periods of incarceration or detention.

(a) To the extent permitted by federal law and notwithstanding any other provision of this Code, the Department of Healthcare and Family Services shall not cancel a person's eligibility for medical assistance, nor shall the Department deny a person's application for medical assistance, solely because that person has become or is an inmate of a public institution, including, but not limited to, a county jail, juvenile detention center, or State correctional facility. The person may be and remain enrolled for medical assistance as long as all other eligibility criteria are met.

(b) The Department may adopt rules to permit a person to apply for medical assistance while he or she is an inmate of a public institution as described in subsection (a). The rules may limit applications to persons who would be likely to qualify for medical assistance if they resided in the community. Any such person who is not already enrolled for medical assistance may apply for medical assistance prior to the date of scheduled release or discharge from a penal institution or county jail or similar status.

(c) Except as provided under Section 17 of the County Jail Act, the Department shall not be responsible to provide medical assistance under this Code for any medical care, services, or supplies provided to a person while he or she is an inmate of a public institution as described in subsection

(a). The responsibility for providing medical care shall remain as otherwise provided by law with the Department of Corrections, county, or other arresting authority. The Department may seek federal financial participation, to the extent that it is available and with the cooperation of the Department of Juvenile Justice, the Department of Corrections, or the relevant county, for the costs of those services.

(c-1) Notwithstanding subsection (c), the Department may provide medical assistance under this Code for medical care, services, and supplies provided to a person while he or she is an inmate of a public institution as described in subsection (a) only to the extent required by the federal Medicaid program, the Children's Health Insurance Program, or otherwise authorized under a federally approved 1115 Waiver, State Plan Amendment, or other federal authority. The medical care, services, and supplies covered, and any other standards, limitations, or conditions for eligibility and coverage, shall be established by rule by the Department in accordance with the applicable federal requirement, waiver, State Plan amendment, or other authority.

(d) To the extent permitted under State and federal law, the Department shall develop procedures to expedite required periodic reviews of continued eligibility for persons described in subsection (a).

(e) Counties, the Department of Juvenile Justice, the Department of Human Services, and the Department of

Corrections shall cooperate with the Department in administering this Section. That cooperation shall include managing eligibility processing and sharing information sufficient to inform the Department, in a manner established by the Department, that a person enrolled in the medical assistance program has been detained or incarcerated.

(f) The Department shall resume responsibility for providing medical assistance upon release of the person to the community as long as all of the following apply:

(1) The person is enrolled for medical assistance at the time of release.

(2) Neither a county, the Department of Juvenile Justice, the Department of Corrections, nor any other criminal justice authority continues to bear responsibility for the person's medical care.

(3) The county, the Department of Juvenile Justice, or the Department of Corrections provides timely notice of the date of release in a manner established by the Department.

(g) This Section applies on and after December 31, 2011.

(Source: P.A. 98-139, eff. 1-1-14; 99-415, eff. 8-20-15.)

ARTICLE 190.

Section 190-5. The Illinois Public Aid Code is amended by changing Sections 5-30.1 and 5-30.18 as follows:

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

"Managed care organization" or "MCO" means any entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

"Emergency services" means health care items and services, including inpatient and outpatient hospital services, furnished or required to evaluate and stabilize an emergency medical condition. "Emergency services" include inpatient stabilization services furnished during the inpatient stabilization period. "Emergency services" do not include post-stabilization medical services.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, regardless of the final diagnosis given, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) 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;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) inadequately controlled pain; or

(5) with respect to a pregnant woman who is having contractions:

(A) inadequate time to complete a safe transfer to another hospital before delivery; or

(B) a transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

"Emergency medical screening examination" means a medical screening examination and evaluation by a physician licensed to practice medicine in all its branches or, to the extent permitted by applicable laws, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches to determine whether the need for emergency services exists.

"Health care services" means ~~mean~~ any medical or behavioral health services covered under the medical assistance program that are subject to review under a service authorization program.

"Inpatient stabilization period" means the initial 72 hours of inpatient stabilization services, beginning from the date and time of the order for inpatient admission to the hospital.

"Inpatient stabilization services" means ~~mean~~ emergency services furnished in the inpatient setting at a hospital pursuant to an order for inpatient admission by a physician or other qualified practitioner who has admitting privileges at

the hospital, as permitted by State law, to stabilize an emergency medical condition following an emergency medical screening examination.

"Post-stabilization medical services" means health care services provided to an enrollee that are furnished in a hospital by a provider that is qualified to furnish such services and determined to be medically necessary by the provider and directly related to the emergency medical condition following stabilization.

"Provider" means a facility or individual who is actively enrolled in the medical assistance program and licensed or otherwise authorized to order, prescribe, refer, or render health care services in this State.

"Service authorization determination" means a decision made by a service authorization program in advance of, concurrent to, or after the provision of a health care service to approve, change the level of care, partially deny, deny, or otherwise limit coverage and reimbursement for a health care service upon review of a service authorization request.

"Service authorization program" means any utilization review, utilization management, peer review, quality review, or other medical management activity conducted by an MCO, or its contracted utilization review organization, including, but not limited to, prior authorization, prior approval, pre-certification, concurrent review, retrospective review, or certification of admission, of health care services provided

in the inpatient or outpatient hospital setting.

"Service authorization request" means a request by a provider to a service authorization program to determine whether a health care service meets the reimbursement eligibility requirements for medically necessary, clinically appropriate care, resulting in the issuance of a service authorization determination.

"Utilization review organization" or "URO" means an MCO's utilization review department or a peer review organization or quality improvement organization that contracts with an MCO to administer a service authorization program and make service authorization determinations.

(b) As provided by Section 5-16.12, managed care organizations are subject to the provisions of the Managed Care Reform and Patient Rights Act.

(c) An MCO shall pay any provider of emergency services, including for inpatient stabilization services provided during the inpatient stabilization period, that does not have in effect a contract with the contracted Medicaid MCO. The default rate of reimbursement shall be the rate paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO

capitated rates.

(d) (Blank).

(e) Notwithstanding any other provision of law, the following requirements apply to MCOs in determining payment for all emergency services, including inpatient stabilization services provided during the inpatient stabilization period:

(1) The MCO shall not impose any service authorization program requirements for emergency services, including, but not limited to, prior authorization, prior approval, pre-certification, certification of admission, concurrent review, or retrospective review.

(A) Notification period: Hospitals shall notify the enrollee's Medicaid MCO within 48 hours of the date and time the order for inpatient admission is written. Notification shall be limited to advising the MCO that the patient has been admitted to a hospital inpatient level of care.

(B) If the admitting hospital complies with the notification provisions of subparagraph (A), the Medicaid MCO may not initiate concurrent review before the end of the inpatient stabilization period. If the admitting hospital does not comply with the notification requirements in subparagraph (A), the Medicaid MCO may initiate concurrent review for the continuation of the stay beginning at the end of the 48-hour notification period.

(C) Coverage for services provided during the 48-hour notification period may not be retrospectively denied.

(2) The MCO shall cover emergency services provided to enrollees who are temporarily away from their residence and outside the contracting area to the extent that the enrollees would be entitled to the emergency services if they still were within the contracting area.

(3) The MCO shall have no obligation to cover emergency services provided on an emergency basis that are not covered services under the contract between the MCO and the Department.

(4) The MCO shall not condition coverage for emergency services on the treating provider notifying the MCO of the enrollee's emergency medical screening examination and treatment within 10 days after presentation for emergency services.

(5) The determination of the attending emergency physician, or the practitioner responsible for the enrollee's care at the hospital, of whether an enrollee requires inpatient stabilization services, can be stabilized in the outpatient setting, or is sufficiently stabilized for discharge or transfer to another setting, shall be binding on the MCO. The MCO shall cover and reimburse providers for emergency services as billed by the provider for all enrollees whether the emergency

services are provided by an affiliated or non-affiliated provider, except in cases of fraud. The MCO shall reimburse inpatient stabilization services provided during the inpatient stabilization period and billed as inpatient level of care based on the appropriate inpatient reimbursement methodology.

(6) The MCO's financial responsibility for post-stabilization medical services it has not pre-approved ends when:

(A) a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(B) a plan physician assumes responsibility for the enrollee's care through transfer;

(C) a contracting entity representative and the treating physician reach an agreement concerning the enrollee's care; or

(D) the enrollee is discharged.

(e-5) An MCO shall pay for all post-stabilization medical services as a covered service in any of the following situations:

(1) the MCO or its URO authorized such services;

(2) such services were administered to maintain the enrollee's stabilized condition within one hour after a request to the MCO for authorization of further post-stabilization services;

(3) the MCO or its URO did not respond to a request to authorize such services within one hour;

(4) the MCO or its URO could not be contacted; or

(5) the MCO or its URO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an agreement concerning the enrollee's care and an affiliated provider was unavailable for a consultation, in which case the MCO must pay for such services rendered by the treating non-affiliated provider until an affiliated provider was reached and either concurred with the treating non-affiliated provider's plan of care or assumed responsibility for the enrollee's care. Such payment shall be made at the default rate of reimbursement paid under the State's Medicaid fee-for-service program methodology, including all policy adjusters, including, but not limited to, Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent that such adjustments are incorporated in the development of the applicable MCO capitated rates.

(f) Network adequacy and transparency.

(1) The Department shall:

(A) ensure that an adequate provider network is in place, taking into consideration health professional shortage areas and medically underserved areas;

(B) publicly release an explanation of its process

for analyzing network adequacy;

(C) periodically ensure that an MCO continues to have an adequate network in place;

(D) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet provider directory requirements under Section 5-30.3;

(E) require MCOs to ensure that any Medicaid-certified provider under contract with an MCO and previously submitted on a roster on the date of service is paid for any medically necessary, Medicaid-covered, and authorized service rendered to any of the MCO's enrollees, regardless of inclusion on the MCO's published and publicly available directory of available providers; and

(F) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet each of the requirements under subsection (d-5) of Section 10 of the Network Adequacy and Transparency Act; with necessary exceptions to the MCO's network to ensure that admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in paragraph (3) of subsection (d-5) of Section 10 of the Network Adequacy and Transparency Act is limited to providers or facilities that are Medicaid certified.

(2) Each MCO shall confirm its receipt of information

submitted specific to physician or dentist additions or physician or dentist deletions from the MCO's provider network within 3 days after receiving all required information from contracted physicians or dentists, and electronic physician and dental directories must be updated consistent with current rules as published by the Centers for Medicare and Medicaid Services or its successor agency.

(g) Timely payment of claims.

(1) The MCO shall pay a claim within 30 days of receiving a claim that contains all the essential information needed to adjudicate the claim.

(2) The MCO shall notify the billing party of its inability to adjudicate a claim within 30 days of receiving that claim.

(3) The MCO shall pay a penalty that is at least equal to the timely payment interest penalty imposed under Section 368a of the Illinois Insurance Code for any claims not timely paid.

(A) When an MCO is required to pay a timely payment interest penalty to a provider, the MCO must calculate and pay the timely payment interest penalty that is due to the provider within 30 days after the payment of the claim. In no event shall a provider be required to request or apply for payment of any owed timely payment interest penalties.

(B) Such payments shall be reported separately from the claim payment for services rendered to the MCO's enrollee and clearly identified as interest payments.

(4)(A) The Department shall require MCOs to expedite payments to providers identified on the Department's expedited provider list, determined in accordance with 89 Ill. Adm. Code 140.71(b), on a schedule at least as frequently as the providers are paid under the Department's fee-for-service expedited provider schedule.

(B) Compliance with the expedited provider requirement may be satisfied by an MCO through the use of a Periodic Interim Payment (PIP) program that has been mutually agreed to and documented between the MCO and the provider, if the PIP program ensures that any expedited provider receives regular and periodic payments based on prior period payment experience from that MCO. Total payments under the PIP program may be reconciled against future PIP payments on a schedule mutually agreed to between the MCO and the provider.

(C) The Department shall share at least monthly its expedited provider list and the frequency with which it pays providers on the expedited list.

(g-5) Recognizing that the rapid transformation of the Illinois Medicaid program may have unintended operational challenges for both payers and providers:

(1) in no instance shall a medically necessary covered service rendered in good faith, based upon eligibility information documented by the provider, be denied coverage or diminished in payment amount if the eligibility or coverage information available at the time the service was rendered is later found to be inaccurate in the assignment of coverage responsibility between MCOs or the fee-for-service system, except for instances when an individual is deemed to have not been eligible for coverage under the Illinois Medicaid program; and

(2) the Department shall, by December 31, 2016, adopt rules establishing policies that shall be included in the Medicaid managed care policy and procedures manual addressing payment resolutions in situations in which a provider renders services based upon information obtained after verifying a patient's eligibility and coverage plan through either the Department's current enrollment system or a system operated by the coverage plan identified by the patient presenting for services:

(A) such medically necessary covered services shall be considered rendered in good faith;

(B) such policies and procedures shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the

identified provider industry; and

(C) such rules shall be published for a review and comment period of no less than 30 days on the Department's website with final rules remaining available on the Department's website.

The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

The rules shall be applicable for both MCO coverage and fee-for-service coverage.

If the fee-for-service system is ultimately determined to have been responsible for coverage on the date of service, the Department shall provide for an extended period for claims submission outside the standard timely filing requirements.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of metrics:

(A) claims payment, including timeliness and

accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

(2) The Department shall ensure that the metrics report is accessible to providers online by January 1, 2017.

(3) The metrics shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of associations representing the majority of providers within the identified industry.

(4) Metrics shall be defined and incorporated into the applicable Managed Care Policy Manual issued by the Department.

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to Public Act 100-580, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims

adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims.

(g-8) Dispute resolution process. The Department shall maintain a provider complaint portal through which a provider can submit to the Department unresolved disputes with an MCO. An unresolved dispute means an MCO's decision that denies in whole or in part a claim for reimbursement to a provider for health care services rendered by the provider to an enrollee of the MCO with which the provider disagrees. Disputes shall not be submitted to the portal until the provider has availed itself of the MCO's internal dispute resolution process. Disputes that are submitted to the MCO internal dispute resolution process may be submitted to the Department of Healthcare and Family Services' complaint portal no sooner than 30 days after submitting to the MCO's internal process and not later than 30 days after the unsatisfactory resolution of the internal MCO process or 60 days after submitting the dispute to the MCO internal process. Multiple claim disputes involving the same MCO may be submitted in one complaint, regardless of whether the claims are for different enrollees, when the specific reason for non-payment of the claims involves a common question of fact or policy. Within 10 business days of receipt of a complaint, the Department shall present such disputes to the appropriate MCO, which shall then have 30 days to issue its written proposal to resolve the

dispute. The Department may grant one 30-day extension of this time frame to one of the parties to resolve the dispute. If the dispute remains unresolved at the end of this time frame or the provider is not satisfied with the MCO's written proposal to resolve the dispute, the provider may, within 30 days, request the Department to review the dispute and make a final determination. Within 30 days of the request for Department review of the dispute, both the provider and the MCO shall present all relevant information to the Department for resolution and make individuals with knowledge of the issues available to the Department for further inquiry if needed. Within 30 days of receiving the relevant information on the dispute, or the lapse of the period for submitting such information, the Department shall issue a written decision on the dispute based on contractual terms between the provider and the MCO, contractual terms between the MCO and the Department of Healthcare and Family Services and applicable Medicaid policy. The decision of the Department shall be final. By January 1, 2020, the Department shall establish by rule further details of this dispute resolution process. Disputes between MCOs and providers presented to the Department for resolution are not contested cases, as defined in Section 1-30 of the Illinois Administrative Procedure Act, conferring any right to an administrative hearing.

(g-9)(1) The Department shall publish annually on its website a report on the calculation of each managed care

organization's medical loss ratio showing the following:

(A) Premium revenue, with appropriate adjustments.

(B) Benefit expense, setting forth the aggregate amount spent for the following:

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

(iv) Direct reserves.

(v) Gross recoveries.

(vi) Expenses for activities that improve health care quality as allowed by the Department.

(2) The medical loss ratio shall be calculated consistent with federal law and regulation following a claims runout period determined by the Department.

(g-10)(1) "Liability effective date" means the date on which an MCO becomes responsible for payment for medically necessary and covered services rendered by a provider to one of its enrollees in accordance with the contract terms between the MCO and the provider. The liability effective date shall be the later of:

(A) The execution date of a network participation contract agreement.

(B) The date the provider or its representative submits to the MCO the complete and accurate standardized roster form for the provider in the format approved by the Department.

(C) The provider effective date contained within the Department's provider enrollment subsystem within the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) System.

(2) The standardized roster form may be submitted to the MCO at the same time that the provider submits an enrollment application to the Department through IMPACT.

(3) By October 1, 2019, the Department shall require all MCOs to update their provider directory with information for new practitioners of existing contracted providers within 30 days of receipt of a complete and accurate standardized roster template in the format approved by the Department provided that the provider is effective in the Department's provider enrollment subsystem within the IMPACT system. Such provider directory shall be readily accessible for purposes of selecting an approved health care provider and comply with all other federal and State requirements.

(g-11) The Department shall work with relevant stakeholders on the development of operational guidelines to enhance and improve operational performance of Illinois' Medicaid managed care program, including, but not limited to, improving provider billing practices, reducing claim rejections and inappropriate payment denials, and standardizing processes, procedures, definitions, and response timelines, with the goal of reducing provider and MCO administrative burdens and conflict. The Department shall

include a report on the progress of these program improvements and other topics in its Fiscal Year 2020 annual report to the General Assembly.

(g-12) Notwithstanding any other provision of law, if the Department or an MCO requires submission of a claim for payment in a non-electronic format, a provider shall always be afforded a period of no less than 90 business days, as a correction period, following any notification of rejection by either the Department or the MCO to correct errors or omissions in the original submission.

Under no circumstances, either by an MCO or under the State's fee-for-service system, shall a provider be denied payment for failure to comply with any timely submission requirements under this Code or under any existing contract, unless the non-electronic format claim submission occurs after the initial 180 days following the latest date of service on the claim, or after the 90 business days correction period following notification to the provider of rejection or denial of payment.

(g-13) Utilization Review Standardization and Transparency.

(1) To ensure greater standardization and transparency related to service authorization determinations, for all individuals covered under the medical assistance program, including both the fee-for-service and managed care programs, the Department shall, in consultation with the

MCOs, a statewide association representing the MCOs, a statewide association representing the majority of Illinois hospitals, a statewide association representing physicians, or any other interested parties deemed appropriate by the Department, adopt administrative rules consistent with this subsection, in accordance with the Illinois Administrative Procedure Act.

(2) No later than July 1, 2025, the Department shall in accordance with the Illinois Administrative Procedure Act file emergency rules, and adopt permanent rules no later than October 1, 2025, which govern MCO practices for dates of services on and after July 1, 2025, as follows:

(A) guidelines related to the publication of MCO authorization policies;

(B) procedures that, due to medical complexity, must be reimbursed under the applicable inpatient methodology, when provided in the inpatient setting and billed as an inpatient service;

(C) standardization of administrative forms used in the member appeal process;

(D) limitations on second or subsequent medical necessity review of a health care service already authorized by the MCO or URO under a service authorization program;

(E) standardization of peer-to-peer processes and timelines;

(F) defined criteria for urgent and standard post-acute care and long-term acute care service authorization requests; and

(G) standardized criteria for service authorization programs for authorization of admission to a long-term acute care hospital.

(3) The Department shall expand the scope of the quality and compliance audits conducted by its contracted external quality review organization to include, but not be limited to:

(A) an analysis of the Medicaid MCO's compliance with nationally recognized clinical decision guidelines;

(B) an analysis that compares and contrasts the Medicaid MCO's service authorization determination outcomes to the outcomes of each other MCO plan and the State's fee-for-service program model to evaluate whether service authorization determinations are being made consistently by all Medicaid MCOs to ensure that all individuals are being treated in accordance with equitable standards of care;

(C) an analysis, for each Medicaid MCO, of the number of service authorization requests, including requests for concurrent review and certification of admissions, received, initially denied, overturned through any post-denial process including, but not

limited to, enrollee or provider appeal, peer-to-peer review, or the provider dispute resolution process, denied but approved for a lower or different level of care, and the number denied on final determination; and

(D) provide a written report to the General Assembly, detailing the items listed in this subsection and any other metrics deemed necessary by the Department, by the second April, following June 7, 2024 (the effective date of Public Act 103-593), and each April thereafter. The Department shall make this report available within 30 days of delivery to the General Assembly, on its public facing website.

(h) The Department shall not expand mandatory MCO enrollment into new counties beyond those counties already designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(h-5) Leading indicator data sharing. By January 1, 2024, the Department shall obtain input from the Department of Human Services, the Department of Juvenile Justice, the Department of Children and Family Services, the State Board of Education, managed care organizations, providers, and clinical experts to

identify and analyze key indicators and data elements that can be used in an analysis of lead indicators from assessments and data sets available to the Department that can be shared with managed care organizations and similar care coordination entities contracted with the Department as leading indicators for elevated behavioral health crisis risk for children, including data sets such as the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS), calls made to the State's Crisis and Referral Entry Services (CARES) hotline, health services information from Health and Human Services Innovators, or other data sets that may include key indicators. The workgroup shall complete its recommendations for leading indicator data elements on or before September 1, 2024. To the extent permitted by State and federal law, the identified leading indicators shall be shared with managed care organizations and similar care coordination entities contracted with the Department on or before December 1, 2024 for the purpose of improving care coordination with the early detection of elevated risk. Leading indicators shall be reassessed annually with stakeholder input. The Department shall implement guidance to managed care organizations and similar care coordination entities contracted with the Department, so that the managed care organizations and care coordination entities respond to lead indicators with services and interventions that are designed to help stabilize the child.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after June 16, 2014 (the effective date of Public Act 98-651).

(j) Health care information released to managed care organizations. A health care provider shall release to a Medicaid managed care organization, upon request, and subject to the Health Insurance Portability and Accountability Act of 1996 and any other law applicable to the release of health information, the health care information of the MCO's enrollee, if the enrollee has completed and signed a general release form that grants to the health care provider permission to release the recipient's health care information to the recipient's insurance carrier.

(k) The Department of Healthcare and Family Services, managed care organizations, a statewide organization representing hospitals, and a statewide organization representing safety-net hospitals shall explore ways to support billing departments in safety-net hospitals.

(l) The requirements of this Section added by Public Act 102-4 shall apply to services provided on or after the first day of the month that begins 60 days after April 27, 2021 (the effective date of Public Act 102-4).

(m) Except where otherwise expressly specified, the requirements of this Section added by Public Act 103-593 shall apply to services provided on and after July 1, 2027 ~~July 1,~~

~~2026~~.

(Source: P.A. 103-546, eff. 8-11-23; 103-593, eff. 6-7-24; 103-885, eff. 8-9-24; 104-9, eff. 6-16-25; 104-417, eff. 8-15-25.)

(305 ILCS 5/5-30.18)

(Section scheduled to be repealed on December 31, 2030)

Sec. 5-30.18. Service authorization program performance.

(a) Definitions. As used in this Section:

"Gold Card provider" means a provider identified by each Medicaid Managed Care Organization (MCO) as qualified under the guidelines outlined by the Department in accordance with subsection (c) and thereby granted a service authorization exemption when ordering a health care service.

"Health care service" means any medical or behavioral health service covered under the medical assistance program that is rendered in the inpatient or outpatient hospital setting, including hospital-based clinics, and subject to review under a service authorization program.

"Provider" means an individual actively enrolled in the medical assistance program and licensed or otherwise authorized to order, prescribe, refer, or render health care services in this State, and, as determined by the Department, may also include hospitals that submit service authorization requests.

"Service authorization exemption" means an exception

granted by a Medicaid MCO to a provider under which all service authorization requests for covered health care services, excluding pharmacy services and durable medical equipment, are automatically deemed to be medically necessary, clinically appropriate, and approved for reimbursement as ordered.

"Service authorization program" means any utilization review, utilization management, peer review, quality review, or other medical management activity conducted in advance of, concurrent to, or after the provision of a health care service by a Medicaid MCO, either directly or through a contracted utilization review organization (URO), including, but not limited to, prior authorization, pre-certification, certification of admission, concurrent review, and retrospective review of health care services.

"Service authorization request" means a request by a provider to a service authorization program to determine whether a health care service that is otherwise covered under the medical assistance program meets the reimbursement requirements established by the Medicaid MCO, or its contracted URO, for medically necessary, clinically appropriate care and to issue a service authorization determination.

"Utilization review organization" or "URO" means a managed care organization or other entity that has established or administers one or more service authorization programs.

(b) In consultation with the Medicaid MCOs, a statewide

association representing managed care organizations, a statewide association representing the majority of Illinois hospitals, and a statewide association representing physicians, the Department shall in accordance with the Illinois Administrative Procedure Act, adopt administrative rules no later than October ~~July~~ 1, 2026, consistent with this Section, to require each Medicaid MCO to identify Gold Card providers with such identification initially being effective for health care services provided on and after January 1, 2027 ~~July 1, 2026~~.

(c) The Department shall adopt rules, in accordance with the Illinois Administrative Procedure Act, to implement this Section that include, but are not limited to, the following provisions:

(1) Require each Medicaid MCO to provide a service authorization exemption to a provider if the provider has submitted at least 50 service authorization requests to its service authorization program in the preceding calendar year and the service authorization program approved at least 90% of all service authorization requests, regardless of the type of health care services requested.

(2) Require that service authorization exemptions be limited to services provided in an inpatient or outpatient hospital setting inclusive of hospital-based clinics. Service authorization exemptions under this Section shall

not pertain to pharmacy services and durable medical equipment and supplies.

(3) The service authorization exemption shall be valid for at least one year, shall be made by each Medicaid MCO or its URO, and shall be binding on the Medicaid MCO and its URO.

(4) The provider shall be required to continue to document medically necessary, clinically appropriate care and submit such documentation to the Medicaid MCO for the purpose of continuous performance monitoring. If a provider fails to maintain the 90% service authorization standard, as determined on no more frequent a basis than bi-annually, the provider's service authorization exemption is subject to temporary or permanent suspension.

(5) Require that each Medicaid MCO publish on its provider portal a list of all providers that have qualified for a service authorization exemption or indicate that a provider has qualified for a service authorization exemption on its provider-facing provider roster.

(6) Require that no later than June 1 of each calendar year, each Medicaid MCO shall provide written notification to all providers who qualify for a service authorization exemption, for the subsequent State fiscal year.

(7) Require that each Medicaid MCO or its URO use the policies and guidelines published by the Department to

evaluate whether a provider meets the criteria to qualify for a service authorization exemption and the conditions under which a service authorization exemption may be rescinded, including review of the provider's service authorization determinations during the preceding calendar year.

(8) Require each Medicaid MCO to provide the Department a list of all providers who were denied a service authorization exemption or had a previously granted service authorization exemption suspended, with such denials being subject to an annual audit conducted by an independent third-party URO to ensure their appropriateness.

(A) The independent third-party URO shall issue a written report consistent with this paragraph.

(B) The independent third-party URO shall not be owned by, affiliated with, or employed by any Medicaid MCO or its contracted URO, nor shall it have any financial interest in the Medicaid MCO's service authorization exemption program.

(d) Each Medicaid MCO must have a standard method to accept and process professional claims and facility claims, as billed by the provider, for a health care service that is rendered, prescribed, or ordered by a provider granted a service authorization exemption, except in cases of fraud.

(e) A service authorization program shall not deny,

partially deny, reduce the level of care, or otherwise limit reimbursement to the rendering or supervising provider, including the rendering facility, for health care services ordered by a provider who qualifies for a service authorization exemption, except in cases of fraud.

(f) This Section is repealed on December 31, 2030.

(Source: P.A. 103-593, eff. 6-7-24; 104-9, eff. 6-16-25.)

ARTICLE 195.

Section 195-5. The Illinois Insurance Code is amended by changing Section 370c.1 as follows:

(215 ILCS 5/370c.1)

Sec. 370c.1. Mental, emotional, nervous, or substance use disorder or condition parity.

(a) On and after July 23, 2021 (the effective date of Public Act 102-135), every insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions shall ensure prior to policy issuance that:

(1) the financial requirements applicable to such

mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant financial requirements applied to substantially all hospital and medical benefits covered by the policy and that there are no separate cost-sharing requirements that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits; and

(2) the treatment limitations applicable to such mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant treatment limitations applied to substantially all hospital and medical benefits covered by the policy and that there are no separate treatment limitations that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits.

(b) The following provisions shall apply concerning aggregate lifetime limits:

(1) In the case of a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace amended, delivered, issued, or renewed in this State on or after September 9, 2015 (the effective date of Public Act 99-480) that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions the

following provisions shall apply:

(A) if the policy does not include an aggregate lifetime limit on substantially all hospital and medical benefits, then the policy may not impose any aggregate lifetime limit on mental, emotional, nervous, or substance use disorder or condition benefits; or

(B) if the policy includes an aggregate lifetime limit on substantially all hospital and medical benefits (in this subsection referred to as the "applicable lifetime limit"), then the policy shall either:

(i) apply the applicable lifetime limit both to the hospital and medical benefits to which it otherwise would apply and to mental, emotional, nervous, or substance use disorder or condition benefits and not distinguish in the application of the limit between the hospital and medical benefits and mental, emotional, nervous, or substance use disorder or condition benefits; or

(ii) not include any aggregate lifetime limit on mental, emotional, nervous, or substance use disorder or condition benefits that is less than the applicable lifetime limit.

(2) In the case of a policy that is not described in paragraph (1) of subsection (b) of this Section and that

includes no or different aggregate lifetime limits on different categories of hospital and medical benefits, the Director shall establish rules under which subparagraph (B) of paragraph (1) of subsection (b) of this Section is applied to such policy with respect to mental, emotional, nervous, or substance use disorder or condition benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(c) The following provisions shall apply concerning annual limits:

(1) In the case of a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace amended, delivered, issued, or renewed in this State on or after September 9, 2015 (the effective date of Public Act 99-480) that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions the following provisions shall apply:

(A) if the policy does not include an annual limit on substantially all hospital and medical benefits, then the policy may not impose any annual limits on mental, emotional, nervous, or substance use disorder or condition benefits; or

(B) if the policy includes an annual limit on substantially all hospital and medical benefits (in this subsection referred to as the "applicable annual limit"), then the policy shall either:

(i) apply the applicable annual limit both to the hospital and medical benefits to which it otherwise would apply and to mental, emotional, nervous, or substance use disorder or condition benefits and not distinguish in the application of the limit between the hospital and medical benefits and mental, emotional, nervous, or substance use disorder or condition benefits; or

(ii) not include any annual limit on mental, emotional, nervous, or substance use disorder or condition benefits that is less than the applicable annual limit.

(2) In the case of a policy that is not described in paragraph (1) of subsection (c) of this Section and that includes no or different annual limits on different categories of hospital and medical benefits, the Director shall establish rules under which subparagraph (B) of paragraph (1) of subsection (c) of this Section is applied to such policy with respect to mental, emotional, nervous, or substance use disorder or condition benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the

weighted average of the annual limits applicable to such categories.

(d) With respect to mental, emotional, nervous, or substance use disorders or conditions, an insurer shall use policies and procedures for the election and placement of mental, emotional, nervous, or substance use disorder or condition treatment drugs on its ~~their~~ formulary that are no less favorable to the insured as those policies and procedures the insurer uses for the selection and placement of drugs for medical or surgical conditions and shall follow the expedited coverage determination requirements for substance abuse treatment drugs set forth in Section 45.2 of the Managed Care Reform and Patient Rights Act.

(e) This Section shall be interpreted in a manner consistent with all applicable federal parity regulations including, but not limited to, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, final regulations issued under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and final regulations applying the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicaid managed care organizations, the Children's Health Insurance Program, and alternative benefit plans.

(f) The provisions of subsections (b) and (c) of this Section shall not be interpreted to allow the use of lifetime or annual limits otherwise prohibited by State or federal law.

(g) As used in this Section:

"Financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket maximums, but does not include an aggregate lifetime limit or an annual limit subject to subsections (b) and (c).

"Mental, emotional, nervous, or substance use disorder or condition" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

"Treatment limitation" includes limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. "Treatment limitation" includes both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of treatment. A permanent exclusion of all benefits for a particular condition or disorder shall not be considered a treatment limitation. "Nonquantitative treatment limitations" means those limitations as described under federal regulations (26 CFR 54.9812-1). "Nonquantitative treatment limitations" include,

but are not limited to, those limitations described under federal regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR 146.136.

(h) The Department of Insurance shall implement the following education initiatives:

(1) By January 1, 2016, the Department shall develop a plan for a Consumer Education Campaign on parity. The Consumer Education Campaign shall focus its efforts throughout the State and include trainings in the northern, southern, and central regions of the State, as defined by the Department, as well as each of the 5 managed care regions of the State as identified by the Department of Healthcare and Family Services. Under this Consumer Education Campaign, the Department shall: (1) by January 1, 2017, provide at least one live training in each region on parity for consumers and providers and one webinar training to be posted on the Department website and (2) establish a consumer hotline to assist consumers in navigating the parity process by March 1, 2017. By January 1, 2018 the Department shall issue a report to the General Assembly on the success of the Consumer Education Campaign, which shall indicate whether additional training is necessary or would be recommended.

(2) (Blank).

(3) Not later than March ~~January~~ 1 of each year, beginning in calendar year 2027, the Department, in

conjunction with the Department of Healthcare and Family Services, shall issue a joint report to the General Assembly. The joint report shall be posted on each respective department's website ~~and provide an educational presentation to the General Assembly~~. The report and presentation shall:

(A) Cover the methodology the Departments use to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any federal regulations or guidance relating to the compliance and oversight of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and 42 U.S.C. 18031(j).

(B) Cover the methodology the Departments use to check for compliance with this Section and Sections 356z.23 and 370c of this Code.

(C) Identify market conduct examinations or, in the case of the Department of Healthcare and Family Services, audits conducted or completed during the preceding 12-month period regarding compliance with parity in mental, emotional, nervous, and substance use disorder or condition benefits under State and federal laws and summarize the results of such market conduct examinations and audits. This shall include:

(i) the number of market conduct examinations

and audits initiated and completed;

(ii) the benefit classifications examined by each market conduct examination and audit;

(iii) the subject matter of each market conduct examination and audit, including quantitative and nonquantitative treatment limitations; and

(iv) a summary of the basis for the final decision rendered in each market conduct examination and audit.

Individually identifiable information shall be excluded from the reports consistent with federal privacy protections.

(D) Detail any educational or corrective actions the Departments have taken to ensure compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), this Section, and Sections 356z.23 and 370c of this Code.

(E) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the Departments find appropriate, posting the report on the Departments' websites.

(i) The Parity Advancement Fund is created as a special fund in the State treasury. Moneys from fines and penalties

collected from insurers for violations of this Section shall be deposited into the Fund. Moneys deposited into the Fund for appropriation by the General Assembly to the Department shall be used for the purpose of providing financial support of the Consumer Education Campaign, parity compliance advocacy, and other initiatives that support parity implementation and enforcement on behalf of consumers.

(j) (Blank).

(j-5) The Department of Insurance shall collect the following information:

(1) The number of employment disability insurance plans offered in this State, including, but not limited to:

(A) individual short-term policies;

(B) individual long-term policies;

(C) group short-term policies; and

(D) group long-term policies.

(2) The number of policies referenced in paragraph (1) of this subsection that limit mental health and substance use disorder benefits.

(3) The average defined benefit period for the policies referenced in paragraph (1) of this subsection, both for those policies that limit and those policies that have no limitation on mental health and substance use disorder benefits.

(4) Whether the policies referenced in paragraph (1)

of this subsection are purchased on a voluntary or non-voluntary basis.

(5) The identities of the individuals, entities, or a combination of the 2 that assume the cost associated with covering the policies referenced in paragraph (1) of this subsection.

(6) The average defined benefit period for plans that cover physical disability and mental health and substance abuse without limitation, including, but not limited to:

(A) individual short-term policies;

(B) individual long-term policies;

(C) group short-term policies; and

(D) group long-term policies.

(7) The average premiums for disability income insurance issued in this State for:

(A) individual short-term policies that limit mental health and substance use disorder benefits;

(B) individual long-term policies that limit mental health and substance use disorder benefits;

(C) group short-term policies that limit mental health and substance use disorder benefits;

(D) group long-term policies that limit mental health and substance use disorder benefits;

(E) individual short-term policies that include mental health and substance use disorder benefits without limitation;

(F) individual long-term policies that include mental health and substance use disorder benefits without limitation;

(G) group short-term policies that include mental health and substance use disorder benefits without limitation; and

(H) group long-term policies that include mental health and substance use disorder benefits without limitation.

The Department shall present its findings regarding information collected under this subsection (j-5) to the General Assembly no later than April 30, 2024. Information regarding a specific insurance provider's contributions to the Department's report shall be exempt from disclosure under paragraph (t) of subsection (1) of Section 7 of the Freedom of Information Act. The aggregated information gathered by the Department shall not be exempt from disclosure under paragraph (t) of subsection (1) of Section 7 of the Freedom of Information Act.

(k) An insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions shall submit an annual report, the format and definitions for which will be

determined by the Department and the Department of Healthcare and Family Services and posted on their respective websites, starting on September 1, 2023 and annually thereafter, that contains the following information separately for inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency care benefits, and prescription drug benefits in the case of accident and health insurance or qualified health plans, or inpatient, outpatient, emergency care, and prescription drug benefits in the case of medical assistance:

(1) A summary of the plan's pharmacy management processes for mental, emotional, nervous, or substance use disorder or condition benefits compared to those for other medical benefits.

(2) A summary of the internal processes of review for experimental benefits and unproven technology for mental, emotional, nervous, or substance use disorder or condition benefits and those for other medical benefits.

(3) A summary of how the plan's policies and procedures for utilization management for mental, emotional, nervous, or substance use disorder or condition benefits compare to those for other medical benefits.

(4) A description of the process used to develop or select the medical necessity criteria for mental, emotional, nervous, or substance use disorder or condition

benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(5) Identification of all nonquantitative treatment limitations that are applied to both mental, emotional, nervous, or substance use disorder or condition benefits and medical and surgical benefits within each classification of benefits.

(6) The results of an analysis that demonstrates that for the medical necessity criteria described in subparagraph (A) and for each nonquantitative treatment limitation identified in subparagraph (B), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental, emotional, nervous, or substance use disorder or condition benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

(A) identify the factors used to determine that a nonquantitative treatment limitation applies to a

benefit, including factors that were considered but rejected;

(B) identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation;

(C) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, for mental, emotional, nervous, or substance use disorder or condition benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits;

(D) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental, emotional, nervous, or substance use disorder or condition benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) disclose the specific findings and conclusions reached by the insurer that the results of the analyses described in subparagraphs (C) and (D) indicate that the insurer is in compliance with this Section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations, which include ~~includes~~ 42 CFR Parts 438, 440, and 457 and 45 CFR 146.136 and any other related federal regulations found in the Code of Federal Regulations.

(7) Any other information necessary to clarify data provided in accordance with this Section requested by the Director, including information that may be proprietary or have commercial value, under the requirements of Section 30 of the Viatical Settlements Act of 2009.

(l) An insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions on or after January 1, 2019 (the effective date of Public Act 100-1024) shall, in advance of the plan year, make available to the Department or, with respect to medical assistance, the Department of Healthcare and Family Services and to all plan participants and beneficiaries the information required in subparagraphs (C) through (E) of paragraph (6) of subsection

(k). For plan participants and medical assistance beneficiaries, the information required in subparagraphs (C) through (E) of paragraph (6) of subsection (k) shall be made available on a publicly available website whose web address is prominently displayed in plan and managed care organization informational and marketing materials.

(m) In conjunction with its compliance examination program conducted in accordance with the Illinois State Auditing Act, the Auditor General shall undertake a review of compliance by the Department and the Department of Healthcare and Family Services with Section 370c and this Section. Any findings resulting from the review conducted under this Section shall be included in the applicable State agency's compliance examination report. Each compliance examination report shall be issued in accordance with Section 3-14 of the Illinois State Auditing Act. A copy of each report shall also be delivered to the head of the applicable State agency and posted on the Auditor General's website.

(Source: P.A. 103-94, eff. 1-1-24; 103-105, eff. 6-27-23; 103-605, eff. 7-1-24; 104-334, eff. 8-15-25.)

ARTICLE 200.

Section 200-5. The Illinois Public Aid Code is amended by changing Sections 5F-10, 5F-15, and 5F-35 as follows:

(305 ILCS 5/5F-10)

Sec. 5F-10. Scope. This Article applies to policies and contracts amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 98th General Assembly for the nursing home component of the Medicare-Medicaid Alignment Initiative and the Managed Long-Term Services and Support Program, a fully integrated dual eligible special needs plan, or any managed care plan for persons who are dually eligible for Medicare and Medicaid. This Article does not diminish a managed care organization's duties and responsibilities under other federal or State laws or rules adopted under those laws and the 3-way Medicare-Medicaid Alignment Initiative contract and the Managed Long-Term Services and Support Program contract.
(Source: P.A. 98-651, eff. 6-16-14; 99-719, eff. 1-1-17.)

(305 ILCS 5/5F-15)

Sec. 5F-15. Definitions. As used in this Article:

"Appeal" means any of the procedures that deal with the review of adverse organization determinations on the health care services the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services, such that a delay would adversely affect the health of the enrollee or on any amounts the enrollee must pay for a service, as defined under 42 CFR 422.566(b). These procedures include reconsiderations by the

managed care organization and, if necessary, an independent review entity as provided by the Health Carrier External Review Act, hearings before administrative law judges, review by the Medicare Appeals Council, and judicial review.

"Demonstration Project" means the nursing home component of the Medicare-Medicaid Alignment Initiative Demonstration Project, a fully integrated dual eligible special needs plan, or any managed care plan for persons who are dually eligible for Medicare and Medicaid.

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

"Enrollee" means an individual who resides in a nursing home or is qualified to be admitted to a nursing home and is enrolled with a managed care organization participating in the Demonstration Project.

"Health care services" means the diagnosis, treatment, and prevention of disease and includes medication, primary care, nursing or medical care, mental health treatment, psychiatric rehabilitation, memory loss services, physical, occupational, and speech rehabilitation, enhanced care, medical supplies and equipment and the repair of such equipment, and assistance with activities of daily living.

"Managed care organization" or "MCO" means an entity that meets the definition of health maintenance organization as defined in the Health Maintenance Organization Act, is licensed, regulated and in good standing with the Department

of Insurance, and is authorized to participate in the nursing home component of the Medicare-Medicaid Alignment Initiative Demonstration Project by a 3-way contract with the Department of Healthcare and Family Services and the Centers for Medicare and Medicaid Services.

"Medical professional" means a physician, physician assistant, or nurse practitioner.

"Medically necessary" means health care services that a medical professional, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms, and that are: (i) in accordance with the generally accepted standards of medical practice; (ii) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and (iii) not primarily for the convenience of the patient, a medical professional, other health care provider, caregiver, family member, or other interested party.

"Nursing home" means a facility licensed under the Nursing Home Care Act.

"Nurse practitioner" means an individual properly licensed as a nurse practitioner under the Nurse Practice Act.

"Physician" means an individual licensed to practice in all branches of medicine under the Medical Practice Act of 1987.

"Physician assistant" means an individual properly licensed under the Physician Assistant Practice Act of 1987.

"Resident" means an enrollee who is receiving personal or medical care, including, but not limited to, mental health treatment, psychiatric rehabilitation, physical rehabilitation, and assistance with activities of daily living, from a nursing home.

"RAI Manual" means the most recent Resident Assessment Instrument Manual, published by the Centers for Medicare and Medicaid Services.

"Resident's representative" means a person designated in writing by a resident to be the resident's representative or the resident's guardian, as described by the Nursing Home Care Act.

"SNFist" means a medical professional specializing in the care of individuals residing in nursing homes employed by or under contract with an ~~a~~ MCO.

"Transition period" means a period of time immediately following enrollment into the Demonstration Project or an enrollee's movement from one managed care organization to another managed care organization or one care setting to another care setting.

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

(305 ILCS 5/5F-35)

Sec. 5F-35. Reimbursement. The Department shall provide

each managed care organization with the quarterly facility-specific ~~RUG-IV~~ nursing component per diem along with any add-ons for enhanced care services, support component per diem, and capital component per diem effective for each nursing home under contract with the managed care organization.

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

ARTICLE 210.

Section 210-5. The Nursing Home Care Act is amended by adding Article IIIB as follows:

(210 ILCS 45/Art. IIIB heading new)

ARTICLE IIIB. COTTAGE STYLE NURSING HOMES

(210 ILCS 45/3B-100 new)

Sec. 3B-100. Definitions. As used in this Article:

"Clinical support team" (CST) means non-universal team members who provide support services throughout the campus. The CST provides support to self-directed or self-managed work teams. The CST includes, but is not limited to, the Administrator, Director of Nursing, Assistant Director of Nursing, and Minimum Data Set nurse.

"Cottage style" or "cottage style facilities" means small, free-standing, self-contained homes that:

(1) Surround or are adjacent to a central administration unit.

(2) Provide up to 12 private residents' rooms that are shared only at the request of a resident to accommodate a spouse, partner, or family member. A spouse that does not meet medical criteria for nursing facility placement may reside in the room assigned to a spouse who is admitted to the facility and who meets medical criteria for admission. The facility may charge the spouse who does not meet medical criteria for room and board, as well as other services so long as the facility meets all requirements or cost reporting.

(3) Have a full, accessible private bathroom for each resident room that contains, at a minimum, a toilet, sink, and shower.

(4) Have the appearance of a residential dwelling for both the exterior and the interior.

(5) Have residents' rooms constructed around a central, communal, family-style open space that includes a hearth room, dining area, and residential-style kitchen. The central communal area shall contain a living area where residents and staff may socialize, dine, and prepare food together that, at a minimum, provides a living room seating area, a dining area large enough for a single table serving all residents in the home plus 2 staff members, and an open full kitchen. The communal area may

include a gas fireplace with a fixed, "stay-cool" glass screen.

(6) Have all residents' room entrances visible from the central communal area.

(7) Each communal area may not exceed a ratio of one communal area to 12 resident rooms.

(8) Two cottages may share a centralized kitchen and laundry, but each may not exceed a ratio of one kitchen/laundry to 24 resident rooms.

(9) Contains residential-style design approach, scale, details, and materials throughout the home that are similar to the typical residential designs and finishes in the immediate surrounding community and does not contain or utilize commercial and institutional elements and products such as a nurse station, medication carts, hospital or office type fluorescent lighting, acoustical tile ceilings, institutional-style railings, room numbering, and labeling and signage that would not normally be found in a private home setting.

Where rules require specific institutional elements, every effort shall be made to provide the institutional elements in a manner consistent with what might be found in a new private home in the community (such as residential wall sconces used for required nurse call lights).

(10) Have outdoor space that:

(A) allows residents to ambulate, with or without assistive devices such as wheelchairs or walkers;

(B) signals staff wirelessly when someone enters the outdoor space from the cottage style home;

(C) is partially covered to protect from sun and elements under the covered area; and

(D) provides for outdoor activities.

(11) Utilize a wireless alert or call system. The system shall also include, for residents who have been care planned to be at risk for wandering or elopement, location bracelets that permit residents to signal for assistance and enable staff to locate residents. Wired call or alert systems and overhead paging are not permitted.

(12) Utilize a wireless communication and notification system for staff. The system shall provide a means for notification of staff both in the home and in other homes or other areas of the facility occupied by other staff.

(13) Contain ample natural light in each habitable space provided through exterior windows and other means, with window areas, exclusive of skylights and clerestories, being a minimum of 10% of the area of the room.

(14) Have built-in safety features (such as magnetic locks on cabinets with chemicals or knives) to allow all areas of the house, including the kitchen and any staff

office, to be accessible to the residents during the majority of the day and night.

(15) Provide self-directed care for residents through the establishment of self-managed or self-directed work teams consisting of certified nursing assistants.

(16) Prepare and cook at least 80% of resident meals in the cottage style home. Nothing in this item (16) prohibits the consumption of foods that are:

(A) prepared outside the cottage style home by family, acquaintances, or social organizations such as churches;

(B) grown in or on the grounds of the cottage style home by residents or staff; or

(C) prepared by local retail eating establishments that are licensed or inspected based on local, State, or federal laws.

(17) Train all staff involved in the operation of the project in the philosophy, operations, and skills required to implement and maintain self-directed care, self-directed or self-managed work teams, a non-institutional approach to life and care in long-term care, appropriate safety and emergency skills, and other elements required for successful operations and outcomes of the project.

(18) Are designed to be fully accessible for persons with disabilities.

(19) Have overhead lift tracks that run from the bed into the bathroom in at least 30% of resident rooms.

(20) Have at least one lift motor for each cottage style home.

(21) Have separate slings for each resident in the facility who requires a lift.

(22) Are not connected to, or share, any area that would not typically be connected or shared between private homes in the surrounding community (such as a driveway).

(23) Provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan.

(24) Maintain a staffing plan compliant with the minimum direct care staffing ratios required by this Act, the Illinois Administrative Code, and any other applicable State or federal law.

(25) Maintain all professional licensure for staff and employees in accordance with applicable State laws, including, but not limited to, Department of Financial and Professional Regulation requirements.

(26) Comply with any applicable State and federal consent decrees.

(27) Obtain proof and documentation of federal approval by the Centers for Medicare and Medicaid Services.

"Home" means each discrete cottage style unit housing up to 12 private residents' rooms.

"Person-directed care" means a holistic model that takes into consideration each resident's physical, mental, and social needs in the development of a care and treatment plan and the delivery of services that is driven to the greatest extent possible by resident choice, as opposed to an institutional medical model that is schedule and task driven.

"Self-managed or self-directed work team" means the universal workers assigned to a specific cottage style home and who determine, plan, and manage day-to-day activities in the house with little or no direct supervision.

"Food safety" means a method of ensuring safe preparation and delivery of food for and to residents.

"Family-style dining" means residential-style dining, in which all food is placed in serving bowls, platters, and similar residential serving dishes on the table, residents and staff dine together, and residents are encouraged to serve themselves or serve themselves with help from staff.

"Universal or flexible worker" means a certified nursing assistant who has received additional training in the areas of dietary, housekeeping, activities, and laundry and is a member of the self-managed or self-directed work team.

(210 ILCS 45/3B-105 new)

Sec. 3B-105. Intent. This Article creates a framework that

encourages the construction and operation of skilled nursing facilities that are consistent with State and federal laws and referred to as "cottage style". The cottage style model is a facility model resulting in a residential-style physical plant and specific principles of staff interaction. The cottage style model utilizes small, free-standing, self-contained homes. A single cottage consists of up to 12 private rooms, each with full bathrooms. Two cottages may share a common kitchen and laundry but the maximum ratio of 1 kitchen and laundry per 24 rooms must be maintained. The residents' rooms are constructed around a central, communal, family-style open space that includes a hearth room and dining area. All residents' room entrances are visible from the central communal area. The maximum ratio of one communal area per 12 rooms must be maintained. Each home is built to blend architecturally with neighboring homes.

(210 ILCS 45/3B-110 new)

Sec. 3B-110. Applicability. Nursing homes that meet the requirements of this Article to be designated as a cottage style nursing home are still subject to all requirements of this Act, administrative rules, and applicable State or federal laws. All requirements of this Article are additional requirements necessary to be designated as cottage style as defined in Section 3B-100.

(210 ILCS 45/3B-115 new)

Sec. 3B-115. License designation. During the initial licensure survey required under Section 3-109 of this Act, the Department must also review compliance with this Article. The Department must indicate, on licenses issued under this Act, "cottage style" for nursing homes that meet the requirements of this Article.

(210 ILCS 45/3B-120 new)

Sec. 3B-120. Staff Training.

(a) In addition to any State or federal training requirements pertaining to long-term care facilities, each certified nursing assistant (CNA) working in a cottage style home shall complete the following 40 hours of training, to include, but not be limited to:

(1) Cottage Style Model v. Traditional Model, a minimum of 2 hours covering at least the following topics:

(A) Meaningful Engagement. Development of, and appreciation for, activities designed to meet the individual's personal preferences and needs.

(B) Organizational Culture Change.

(2) Universal or Flexible Worker, a minimum of 2 hours covering at least the following topics:

(A) Concept.

(B) Responsibilities of the Worker.

(3) Person-Directed Care, a minimum of 2 hours

covering at least the following topics:

(A) Concepts and Relationship Building.

(B) Execution. How elder preferences shape workflow.

(4) Self-Managed or Self-Directed Work Team, a minimum of 4 hours covering at least the following topics:

(A) Concept.

(B) Responsibilities.

(C) Conflict Resolution and Learning Circles.

(5) Food Safety, a minimum of 22 hours covering at least the following topics:

(A) Safety.

(B) Contamination.

(C) Allergies.

(D) Therapeutic Diets.

(E) Thickening Agents.

(F) Food Preparation.

(G) Family Style Dining.

(H) Cottage Equipment Use. Appliance usage and safety.

(6) Emergency Situations and Evacuation, a minimum of 2 hours covering at least the following topics:

(A) Fire Drills.

(B) Tornado Drills.

(C) Disaster Drills.

(D) Evacuation.

(E) Environmental Policy.

(7) Cottage Orientation, a minimum of 2 hours covering at least the following topics:

(A) Phone System.

(B) Call System.

(C) Cleaning Supply Storage.

(D) Cleaning Supply Usage.

(E) Workplace Organization.

(8) Communication, a minimum of 2 hours covering at least the following topics:

(A) Communication Skills.

(B) Coaching Skills.

(C) Accountability.

(D) Support.

(9) Observation Skills, a minimum of 2 hours covering at least the following topics:

(A) How to obtain a history from family.

(B) How to modify a care plan.

(C) How to identify a resident's change in condition.

(b) Upon opening and for the first 90 days of continuous operation of a cottage style home, all CNAs working in that home shall complete all of the required training listed in subsection (a) prior to providing services in the cottage style home.

(c) After a cottage style home has been in continuous

operation servicing residents for at least 90 days, each CNA assigned to the cottage style home for the first time, and who has not been trained in accordance with subsections (a) and (b), shall complete the following 16-hour training schedule before working with residents:

(1) Cottage Style Model v. Traditional Model, a minimum of 1.5 hours.

(2) Universal or Flexible Worker, a minimum of 1.5 hours.

(3) Person-Directed Care, a minimum of 3 hours.

(4) Self-Managed or Self-Directed Work Team, a minimum of 3 hours.

(5) Food Safety, a minimum of 3 hours.

(6) Family Style Dining, a minimum of one hour.

(7) Emergency Situations and Evacuations, a minimum of one hour.

(8) Cottage Equipment Use, a minimum of one hour.

(9) Cottage Orientation, a minimum of one hour.

Following the 16-hour training the CNA shall complete the remaining 24 hours of training listed in subsection (a) within 90 days.

(d) All shared common staff shall undergo the following training within 45 days of the opening of the first cottage style home:

(1) Cottage Style Model v. Traditional Model, a minimum of 1.5 hours.

(2) Clinical Support Team, a minimum of one hour.

(3) Universal or Flexible Worker, a minimum of one hour.

(4) Self-Managed or Self-Directed Work Team, a minimum of 3 hours.

(5) Person-Directed Care, a minimum of 3 hours.

(6) Team Communication, a minimum of one hour.

(7) Learning Circles, a minimum of one hour.

(8) Understanding Aging in the Elderly, a minimum of one hour.

(9) Cottage Systems, a minimum of 2 hours.

(e) Each facility seeking designation as a cottage style facility shall provide to the Department a syllabus, a list of required reference and study materials, and a proposed curriculum of training as required under this Section. As used in this Section, "curriculum" means a detailed study guide that states the learning objectives and provides information or materials designed to impart to the student or trainee the necessary skills, knowledge, or ability required under the learning objectives.

(f) Facilities must keep all trainings current with all changes in best practices and local, State, and federal laws, rules, regulations, and guidance.

(210 ILCS 45/3B-125 new)

Sec. 3B-125. Implementation. The Department may adopt

administrative rules to implement any part of this Article; however, all provisions of this Article are fully effective upon taking effect even if administrative rules have not been adopted.

Section 210-10. The Illinois Public Aid Code is amended by adding Section 5-5.2a as follows:

(305 ILCS 5/5-5.2a new)

Sec. 5-5.2a. Cottage style nursing home reimbursement adjustment.

(a) As used in this Section, "cottage style nursing home" means a nursing home meeting the requirements under Article IIIB of the Nursing Home Care Act.

(b) Subject to any necessary federal approval, for dates of service on and after July 1, 2027, the Department shall reimburse cottage style nursing homes with a per diem add-on of at least $50.

(c) This per diem add-on amount is in addition to all amounts reimbursed to a nursing home under this Code. To account for the unique person-directed care model in cottage style nursing homes, the Department may increase the initial default rates of a new cottage style nursing home until data required to calculate those rates are available.

ARTICLE 215.

Section 215-5. The Illinois Public Aid Code is amended by changing Section 5-5e.1 as follows:

(305 ILCS 5/5-5e.1)

Sec. 5-5e.1. Safety-Net Hospitals.

(a) A Safety-Net Hospital is an Illinois hospital that:

(1) is licensed by the Department of Public Health as a general acute care or pediatric hospital; and

(2) is a disproportionate share hospital, as described in Section 1923 of the federal Social Security Act, as determined by the Department; and

(3) meets one of the following:

(A) has a MIUR of at least 40% and a charity percent of at least 4%; or

(B) has a MIUR of at least 50%.

(b) Definitions. As used in this Section:

(1) "Charity percent" means the ratio of (i) the hospital's charity charges for services provided to individuals without health insurance or another source of third party coverage to (ii) the Illinois total hospital charges, each as reported on the hospital's OBRA form.

(2) "MIUR" means Medicaid Inpatient Utilization Rate and is defined as a fraction, the numerator of which is the number of a hospital's inpatient days provided in the hospital's fiscal year ending 3 years prior to the rate

year, to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act, 42 USC 1396a et seq., excluding those persons eligible for medical assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of Section 5-2 of this Article, and the denominator of which is the total number of the hospital's inpatient days in that same period, excluding those persons eligible for medical assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of Section 5-2 of this Article.

(3) "OBRA form" means form HFS-3834, OBRA '93 data collection form, for the rate year.

(4) "Rate year" means the 12-month period beginning on October 1.

(c) Beginning July 1, 2012 and ending on December 31, 2028 ~~2026~~, a hospital that would have qualified for the rate year beginning October 1, 2011 or October 1, 2012 shall be a Safety-Net Hospital.

(c-5) Beginning July 1, 2020 and ending on December 31, 2028 ~~2026~~, a hospital that would have qualified for the rate year beginning October 1, 2020 and was designated a federal rural referral center under 42 CFR 412.96 as of October 1, 2020 shall be a Safety-Net Hospital.

(d) No later than August 15 preceding the rate year, each hospital shall submit the OBRA form to the Department. Prior

to October 1, the Department shall notify each hospital whether it has qualified as a Safety-Net Hospital.

(e) The Department may promulgate rules in order to implement this Section.

(f) Nothing in this Section shall be construed as limiting the ability of the Department to include the Safety-Net Hospitals in the hospital rate reform mandated by Section 14-11 of this Code and implemented under Section 14-12 of this Code and by administrative rulemaking.

(Source: P.A. 101-650, eff. 7-7-20; 101-669, eff. 4-2-21; 102-886, eff. 5-17-22.)

ARTICLE 220.

Section 220-5. The Illinois Administrative Procedure Act is amended by adding Section 5-45.72 as follows:

(5 ILCS 100/5-45.72 new)

Sec. 5-45.72. Emergency rulemaking; Department of Healthcare and Family Services. In order to provide for the expeditious and timely implementation of the federal Medicaid provisions contained in Public Law 119-21, including all corresponding federal regulations and requirements issued by the federal Centers for Medicare and Medicaid Services, the Department of Healthcare and Family Services may adopt emergency rules during fiscal year 2027. Emergency rulemaking

authority will pertain to changes in Public Law 119-21 with implementation dates on or before January 1, 2027, which are addressed in this amendatory Act of the 104th General Assembly. During the 12-month period in which this Section is in effect, the 24-month limitation on the adoption of emergency rules does not apply to the rules adopted under this subsection if such an amendment is due to subsequent federal guidance or other federal requirements pertaining to changes in federal law or regulation. The adoption of emergency rules authorized by this Section shall be deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed one year after the effective date of this amendatory Act of the 104th General Assembly.

Section 220-10. The Illinois Public Aid Code is amended by changing Sections 1-11, 5-2, 5-2.1d, 11-4, 11-5.1, and 11-5.4 as follows:

(305 ILCS 5/1-11)

Sec. 1-11. Citizenship. To the extent not otherwise provided in this Code or federal law, all clients who receive cash or medical assistance under Article III, IV, V, or VI of this Code must meet the citizenship requirements as established in this Section. To be eligible for assistance an individual, who is otherwise eligible, must be either a United States citizen or included in one of the following categories

of non-citizens:

(1) United States veterans honorably discharged and persons on active military duty, and the spouse and unmarried dependent children of these persons;

(2) Refugees under Section 207 of the Immigration and Nationality Act;

(3) Asylees under Section 208 of the Immigration and Nationality Act;

(4) Persons for whom deportation has been withheld under Section 243(h) of the Immigration and Nationality Act;

(5) Persons granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980;

(6) Persons lawfully admitted for permanent residence under the Immigration and Nationality Act;

(7) Parolees, for at least one year, under Section 212(d)(5) of the Immigration and Nationality Act;

(8) Nationals of Cuba or Haiti admitted on or after April 21, 1980;

(9) Amerasians from Vietnam, and their close family members, admitted through the Orderly Departure Program beginning on March 20, 1988;

(10) Persons identified by the federal Office of Refugee Resettlement (ORR) as victims of trafficking;

(11) Persons legally residing in the United States who

were members of a Hmong or Highland Laotian tribe when the tribe helped United States personnel by taking part in a military or rescue operation during the Vietnam era (between August 5, 1965 and May 7, 1975); this also includes the person's spouse, a widow or widower who has not remarried, and unmarried dependent children;

(12) American Indians born in Canada under Section 289 of the Immigration and Nationality Act and members of an Indian tribe as defined in Section 4e of the Indian Self-Determination and Education Assistance Act;

(13) Persons who are a spouse, widow, or child of a U.S. citizen or a spouse or child of a legal permanent resident (LPR) who have been battered or subjected to extreme cruelty by the U.S. citizen or LPR or a member of that relative's family who lived with them, who no longer live with the abuser or plan to live separately within one month of receipt of assistance and whose need for assistance is due, at least in part, to the abuse; and

(14) Persons who are foreign-born victims of trafficking, torture, or other serious crimes as defined in Section 2-19 of this Code.

Those persons who are in the categories set forth in paragraphs ~~subdivisions~~ (6) and (7) of this Section, who enter the United States on or after August 22, 1996, shall not be eligible for 5 years beginning on the date the person entered the United States.

The Illinois Department may, by rule, cover prenatal care or emergency medical care for non-citizens who are not otherwise eligible under this Section. Local governmental units which do not receive State funds may impose their own citizenship requirements and are authorized to provide any benefits and impose any citizenship requirements as are allowed under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193).

In order to implement the federal Medicaid provisions contained in Public Law 119-21, and notwithstanding any other provision of this Section, any category of non-citizens or part thereof listed in paragraphs (1) through (14) of this Section shall not be eligible for medical assistance under Article V of this Code to the extent Public Law 119-21 and any corresponding federal regulations or requirements issued by the federal Centers for Medicare and Medicaid Services excludes such category of non-citizens or part thereof from eligibility, federal financial participation, or other federal funding. This Section shall not require any category of non-citizens or part thereof to be funded at state-only cost under Article V of this Code, unless otherwise provided by State law. The Department shall amend 89 Ill. Adm. Code 120.310 to conform to the provisions of this paragraph effective October 1, 2026.

(Source: P.A. 99-870, eff. 8-22-16.)

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

Sec. 5-2. Classes of persons eligible. Medical assistance under this Article shall be available to any of the following classes of persons in respect to whom a plan for coverage has been submitted to the Governor by the Illinois Department and approved by him. If changes made in this Section 5-2 require federal approval, they shall not take effect until such approval has been received:

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

2. Beginning January 1, 2014, persons otherwise eligible for basic maintenance under Article III, excluding any eligibility requirements that are inconsistent with any federal law or federal regulation, as interpreted by the U.S. Department of Health and Human Services, but who fail to qualify thereunder on the basis of need, and who have insufficient income and resources to meet the costs of necessary medical care, including, but not limited to, the following:

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

(i) their income, as determined by the Illinois Department in accordance with any federal requirements, is equal to or less than 100% of the

federal poverty level; or

(ii) their income, after the deduction of costs incurred for medical care and for other types of remedial care, is equal to or less than 100% of the federal poverty level.

(b) (Blank).

3. (Blank).

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

5.(a) Beginning January 1, 2020, individuals during pregnancy and during the 12-month period beginning on the last day of the pregnancy, together with their infants, whose income is at or below 200% of the federal poverty level. Until September 30, 2019, or sooner if the maintenance of effort requirements under the Patient Protection and Affordable Care Act are eliminated or may be waived before then, individuals during pregnancy and during the 12-month period beginning on the last day of the pregnancy, whose countable monthly income, after the deduction of costs incurred for medical care and for other types of remedial care as specified in administrative rule, is equal to or less than the Medical Assistance-No Grant(C) (MANG(C)) Income Standard in effect on April 1,

2013 as set forth in administrative rule.

(b) The plan for coverage shall provide ambulatory prenatal care to pregnant individuals during a presumptive eligibility period and establish an income eligibility standard that is equal to 200% of the federal poverty level, provided that costs incurred for medical care are not taken into account in determining such income eligibility.

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

6. (a) Subject to federal approval, children younger than age 19 when countable income is at or below 313% of the federal poverty level, as determined by the Department and in accordance with all applicable federal requirements. The Department is authorized to adopt emergency rules to implement the changes made to this

paragraph by Public Act 102-43. Until September 30, 2019, or sooner if the maintenance of effort requirements under the Patient Protection and Affordable Care Act are eliminated or may be waived before then, children younger than age 19 whose countable monthly income, after the deduction of costs incurred for medical care and for other types of remedial care as specified in administrative rule, is equal to or less than the Medical Assistance-No Grant(C) (MANG(C)) Income Standard in effect on April 1, 2013 as set forth in administrative rule.

(b) Children and youth who are under temporary custody or guardianship of the Department of Children and Family Services or who receive financial assistance in support of an adoption or guardianship placement from the Department of Children and Family Services.

7. (Blank).

8. As required under federal law, persons who are eligible for Transitional Medical Assistance as a result of an increase in earnings or child or spousal support received. The plan for coverage for this class of persons shall:

(a) extend the medical assistance coverage to the extent required by federal law; and

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

of coverage, subject to the following:

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

(ii) such coverage shall include all services covered under Illinois' State Medicaid Plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

"Medical assistance" under this paragraph 12 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. The Department must request federal approval of the coverage under this paragraph 12 within 30 days after July 3, 2001 (the effective date of Public Act 92-47).

In addition to the persons who are eligible for medical assistance pursuant to subparagraphs (1) and (2)

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

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

14. Subject to the availability of funds for this purpose, the Department may provide coverage under this Article to persons who

(a) reside in Illinois;

(b) are not eligible under any of the preceding paragraphs of this Section;

(c) meet the income guidelines of paragraph 2(a) of this Section; and

(d) meet one of the following conditions:

(i) have filed an application for asylum status under 8 U.S.C. 1158 that is pending with the appropriate federal agency or have a pending appeal of such an application before a court of competent jurisdiction and are represented either by counsel or by an advocate accredited by the appropriate federal agency and employed by a not-for-profit organization in regard to that application or appeal;

(ii) are receiving services through a federally funded torture treatment center;

(iii) have filed a pending application for T nonimmigrant status pursuant to 8 U.S.C. 1101(a)(15)(T);

(iv) have filed a pending application for U nonimmigrant status pursuant to 8 U.S.C. 1101(a)(15)(U); or

(v) have filed as a derivative family member or are included in the application for item (i), (iii), or (iv) as provided by Department rule.

Medical coverage under this paragraph 14 may be

provided for up to 24 continuous months from the initial eligibility date so long as an individual continues to satisfy the criteria of this paragraph 14. If an individual has an application or appeal pending regarding an application for asylum, T nonimmigrant status, or U nonimmigrant status before the appropriate federal agency for such applications or appeals, eligibility under this paragraph 14 may be extended until a final decision is rendered with respect to the application or appeal, except that an individual who is approved for a U visa continues to qualify for medical coverage under this paragraph 14 as long as the individual meets all other eligibility criteria. The Department shall adopt rules governing the implementation of this paragraph 14.

15. Family Care Eligibility.

(a) On and after July 1, 2012, a parent or other caretaker relative who is 19 years of age or older when countable income is at or below 133% of the federal poverty level. A person may not spend down to become eligible under this paragraph 15.

(b) Eligibility shall be reviewed annually.

(c) (Blank).

(d) (Blank).

(e) (Blank).

(f) (Blank).

(g) (Blank).

(h) (Blank).

(i) Following termination of an individual's coverage under this paragraph 15, the individual must be determined eligible before the person can be re-enrolled.

16. Subject to appropriation, uninsured persons who are not otherwise eligible under this Section who have been certified and referred by the Department of Public Health as having been screened and found to need diagnostic evaluation or treatment, or both diagnostic evaluation and treatment, for prostate or testicular cancer. For the purposes of this paragraph 16, uninsured persons are those who do not have creditable coverage, as defined under the Health Insurance Portability and Accountability Act, or have otherwise exhausted any insurance benefits they may have had, for prostate or testicular cancer diagnostic evaluation or treatment, or both diagnostic evaluation and treatment. To be eligible, a person must furnish a Social Security number. A person's assets are exempt from consideration in determining eligibility under this paragraph 16. Such persons shall be eligible for medical assistance under this paragraph 16 for so long as they need treatment for the cancer. A person shall be considered to need treatment if, in the opinion of the person's treating physician, the person requires therapy directed toward cure or palliation of prostate or

testicular cancer, including recurrent metastatic cancer that is a known or presumed complication of prostate or testicular cancer and complications resulting from the treatment modalities themselves. Persons who require only routine monitoring services are not considered to need treatment. "Medical assistance" under this paragraph 16 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. Notwithstanding any other provision of law, the Department (i) does not have a claim against the estate of a deceased recipient of services under this paragraph 16 and (ii) does not have a lien against any homestead property or other legal or equitable real property interest owned by a recipient of services under this paragraph 16.

17. Persons who, pursuant to a waiver approved by the Secretary of the U.S. Department of Health and Human Services, are eligible for medical assistance under Title XIX or XXI of the federal Social Security Act. Notwithstanding any other provision of this Code and consistent with the terms of the approved waiver, the Illinois Department, may by rule:

(a) Limit the geographic areas in which the waiver program operates.

(b) Determine the scope, quantity, duration, and quality, and the rate and method of reimbursement, of

the medical services to be provided, which may differ from those for other classes of persons eligible for assistance under this Article.

(c) Restrict the persons' freedom in choice of providers.

18. Beginning January 1, 2014, persons aged 19 or older, but younger than 65, who are not otherwise eligible for medical assistance under this Section 5-2, who qualify for medical assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) to the extent permitted under federal law ~~and applicable federal regulations~~, and who have income at or below 133% of the federal poverty level plus 5% for the applicable family size as determined pursuant to 42 U.S.C. 1396a(e)(14) and applicable federal regulations. Persons eligible for medical assistance under this paragraph 18 shall receive coverage for the Health Benefits Service Package as that term is defined in subsection (m) of Section 5-1.1 of this Code. If Illinois' federal medical assistance percentage (FMAP) is reduced below 90% for persons eligible for medical assistance under this paragraph 18, eligibility under this paragraph 18 shall cease no later than the end of the third month following the month in which the reduction in FMAP takes effect.

19. Beginning January 1, 2014, as required under 42 U.S.C. 1396a(a)(10)(A)(i)(IX), persons older than age 18

and younger than age 26 who are not otherwise eligible for medical assistance under paragraphs (1) through (17) of this Section who (i) were in foster care under the responsibility of the State on the date of attaining age 18 or on the date of attaining age 21 when a court has continued wardship for good cause as provided in Section 2-31 of the Juvenile Court Act of 1987 and (ii) received medical assistance under the Illinois Title XIX State Plan or waiver of such plan while in foster care.

20. (Blank).

21. Persons who are not otherwise eligible for medical assistance under this Section who may qualify for medical assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(ii)(XXIII) and 42 U.S.C. 1396(ss) for the duration of any federal or State declared emergency due to COVID-19. Medical assistance to persons eligible for medical assistance solely pursuant to this paragraph 21 shall be limited to any in vitro diagnostic product (and the administration of such product) described in 42 U.S.C. 1396d(a)(3)(B) on or after March 18, 2020, any visit described in 42 U.S.C. 1396o(a)(2)(G), or any other medical assistance that may be federally authorized for this class of persons. The Department may also cover treatment of COVID-19 for this class of persons, or any similar category of uninsured individuals, to the extent authorized under a federally approved 1115 Waiver or other

federal authority. Notwithstanding the provisions of Section 1-11 of this Code, due to the nature of the COVID-19 public health emergency, the Department may cover and provide the medical assistance described in this paragraph 21 to noncitizens who would otherwise meet the eligibility requirements for the class of persons described in this paragraph 21 for the duration of the State emergency period.

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 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 Persons with Disabilities Property Tax Relief Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act.

The Department shall by rule establish the amounts of assets to be disregarded in determining eligibility for medical assistance, which shall at a minimum equal the amounts

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

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

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

Notwithstanding any other provision of this Code, if the United States Supreme Court holds Title II, Subtitle A, Section 2001(a) of Public Law 111-148 to be unconstitutional, or if a holding of Public Law 111-148 makes Medicaid eligibility allowed under Section 2001(a) inoperable, the State or a unit of local government shall be prohibited from enrolling individuals in the Medical Assistance Program as the result of federal approval of a State Medicaid waiver on or after June 14, 2012 (the effective date of Public Act 97-687), and any individuals enrolled in the Medical Assistance Program

pursuant to eligibility permitted as a result of such a State Medicaid waiver shall become immediately ineligible.

Notwithstanding any other provision of this Code, if an Act of Congress that becomes a Public Law eliminates Section 2001(a) of Public Law 111-148, the State or a unit of local government shall be prohibited from enrolling individuals in the Medical Assistance Program as the result of federal approval of a State Medicaid waiver on or after June 14, 2012 (the effective date of Public Act 97-687), and any individuals enrolled in the Medical Assistance Program pursuant to eligibility permitted as a result of such a State Medicaid waiver shall become immediately ineligible.

Effective October 1, 2013, the determination of eligibility of persons who qualify under paragraphs 5, 6, 8, 15, 17, and 18 of this Section shall comply with the requirements of 42 U.S.C. 1396a(e)(14) and applicable federal regulations.

The Department of Healthcare and Family Services, the Department of Human Services, and the Illinois health insurance marketplace shall work cooperatively to assist persons who would otherwise lose health benefits as a result of changes made under Public Act 98-104 to transition to other health insurance coverage.

(Source: P.A. 104-9, eff. 1-1-26.)

(305 ILCS 5/5-2.1d)

Sec. 5-2.1d. Retroactive eligibility. Subject to federal approval and in accordance with applicable federal law and requirements, an ~~An~~ applicant for medical assistance may be eligible ~~for up to 3 months~~ prior to the date of application if the person would have been eligible for medical assistance at the time he or she received the services if he or she had applied, regardless of whether the individual is alive when the application for medical assistance is made. In determining financial eligibility for medical assistance for retroactive months, the Department shall consider the amount of income and resources and exemptions available to a person as of the first day of each of the backdated months for which eligibility is sought. The Department shall, by rule, establish the duration of retroactive eligibility, which shall at a minimum equal the duration of eligibility for federal matching funds.

(Source: P.A. 97-689, eff. 6-14-12.)

(305 ILCS 5/11-4) (from Ch. 23, par. 11-4)

Sec. 11-4. Applications; assistance in making applications. An initial application for public assistance shall be deemed an application for all such benefits to which any person may be entitled except to the extent that the applicant expressly declines in writing to apply for particular benefits. A redetermination of eligibility shall occur at least annually or for any other periodic time period established by the Department by rule that is necessary to

implement the federal Medicaid provisions contained in Public Law 119-21 and any corresponding federal regulations or requirements issued by the federal Centers for Medicare and Medicaid Services. A redetermination ~~The redetermination is an annual redetermination~~ of eligibility is for ~~of~~ current benefits and is not an initial application. The Illinois Department shall provide information in writing about all benefits provided under this Code to any person seeking public assistance. The Illinois Department shall also provide information in writing and orally to all applicants about an election to have financial aid deposited directly in a recipient's savings account or checking account or in any electronic benefits account or accounts as provided in Section 11-3.1, to the extent that those elections are actually available, including information on any programs administered by the State Treasurer to facilitate or encourage the distribution of financial aid by direct deposit or electronic benefits transfer. The Illinois Department shall determine the applicant's eligibility for cash assistance, medical assistance and food stamps unless the applicant expressly declines in writing to apply for particular benefits. The Illinois Department shall adopt policies and procedures to facilitate timely changes between programs that result from changes in categorical eligibility factors.

The County departments, local governmental units and the Illinois Department shall assist applicants for public

assistance to properly complete their applications. Such assistance shall include, but not be limited to, assistance in securing evidence in support of their eligibility.

(Source: P.A. 104-9, eff. 6-16-25.)

(305 ILCS 5/11-5.1)

Sec. 11-5.1. Eligibility verification. Notwithstanding any other provision of this Code, with respect to applications for medical assistance provided under Article V of this Code, eligibility shall be determined in a manner that ensures program integrity and complies with federal laws and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By no later than July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants for medical assistance under this Code. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as

described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub.

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their ~~annual~~ review of eligibility for medical assistance under this Code. Information the Department receives prior to the ~~annual~~ review, including information available to the Department as a result of the recipient's application for other non-Medicaid benefits, that is sufficient to make a determination of continued Medicaid eligibility may be reviewed and verified, and subsequent action taken including client notification of continued Medicaid eligibility. The date of client notification establishes the date for subsequent ~~annual~~ Medicaid eligibility reviews. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. The Department shall send

a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice a notice of cancellation shall be issued to the recipient and coverage shall end no later than the last day of the month following the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By no later than July 1, 2011, require verification of Illinois residency.

The Department, with federal approval, may choose to adopt continuous financial eligibility for a full 12 months for adults on Medicaid.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic

access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data shall be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.

(d) As soon as practical if the data is reasonably available, but no later than January 1, 2017, the Department shall compile on a monthly basis data on eligibility redeterminations of beneficiaries of medical assistance provided under Article V of this Code. In addition to the other data required under this subsection, the Department shall compile on a monthly basis data on the percentage of beneficiaries whose eligibility is renewed through ex parte redeterminations as described in subsection (b) of Section 5-1.6 of this Code, subject to federal approval of the changes made in subsection (b) of Section 5-1.6 by this amendatory Act

of the 102nd General Assembly. This data shall be posted on the Department's website, and data from prior months shall be retained and available on the Department's website. The data compiled and reported shall include the following:

(1) The total number of redetermination decisions made in a month and, of that total number, the number of decisions to continue or change benefits and the number of decisions to cancel benefits.

(2) A breakdown of enrollee language preference for the total number of redetermination decisions made in a month and, of that total number, a breakdown of enrollee language preference for the number of decisions to continue or change benefits, and a breakdown of enrollee language preference for the number of decisions to cancel benefits. The language breakdown shall include, at a minimum, English, Spanish, and the next 4 most commonly used languages.

(3) The percentage of cancellation decisions made in a month due to each of the following:

(A) The beneficiary's ineligibility due to excess income.

(B) The beneficiary's ineligibility due to not being an Illinois resident.

(C) The beneficiary's ineligibility due to being deceased.

(D) The beneficiary's request to cancel benefits.

(E) The beneficiary's lack of response after notices mailed to the beneficiary are returned to the Department as undeliverable by the United States Postal Service.

(F) The beneficiary's lack of response to a request for additional information when reliable information in the beneficiary's account, or other more current information, is unavailable to the Department to make a decision on whether to continue benefits.

(G) Other reasons tracked by the Department for the purpose of ensuring program integrity.

(4) If a vendor is utilized to provide services in support of the Department's redetermination decision process, the total number of redetermination decisions made in a month and, of that total number, the number of decisions to continue or change benefits, and the number of decisions to cancel benefits (i) with the involvement of the vendor and (ii) without the involvement of the vendor.

(5) Of the total number of benefit cancellations in a month, the number of beneficiaries who return from cancellation within one month, the number of beneficiaries who return from cancellation within 2 months, and the number of beneficiaries who return from cancellation within 3 months. Of the number of beneficiaries who return

from cancellation within 3 months, the percentage of those cancellations due to each of the reasons listed under paragraph (3) of this subsection.

(e) The Department shall conduct a complete review of the Medicaid redetermination process in order to identify changes that can increase the use of ex parte redetermination processing. This review shall be completed within 90 days after the effective date of this amendatory Act of the 101st General Assembly. Within 90 days of completion of the review, the Department shall seek written federal approval of policy changes the review recommended and implement once approved. The review shall specifically include, but not be limited to, use of ex parte redeterminations of the following populations:

(1) Recipients of developmental disabilities services.

(2) Recipients of benefits under the State's Aid to the Aged, Blind, or Disabled program.

(3) Recipients of Medicaid long-term care services and supports, including waiver services.

(4) All Modified Adjusted Gross Income (MAGI) populations.

(5) Populations with no verifiable income.

(6) Self-employed people.

The report shall also outline populations and circumstances in which an ex parte redetermination is not a recommended option.

(f) The Department shall explore and implement, as

practical and technologically possible, roles that stakeholders outside State agencies can play to assist in expediting eligibility determinations and redeterminations within 24 months after the effective date of this amendatory Act of the 101st General Assembly. Such practical roles to be explored to expedite the eligibility determination processes shall include the implementation of hospital presumptive eligibility, as authorized by the Patient Protection and Affordable Care Act.

(g) The Department or its designee shall seek federal approval to enhance the reasonable compatibility standard from 5% to 10%.

(h) Reporting. The Department of Healthcare and Family Services and the Department of Human Services shall publish quarterly reports on their progress in implementing policies and practices pursuant to this Section as modified by this amendatory Act of the 101st General Assembly.

(1) The reports shall include, but not be limited to, the following:

(A) Medical application processing, including a breakdown of the number of MAGI, non-MAGI, long-term care, and other medical cases pending for various incremental time frames between 0 to 181 or more days.

(B) Medical redeterminations completed, including: (i) a breakdown of the number of households that were redetermined ex parte and those that were not; (ii)

the reasons households were not redetermined ex parte; and (iii) the relative percentages of these reasons.

(C) A narrative discussion on issues identified in the functioning of the State's Integrated Eligibility System and progress on addressing those issues, as well as progress on implementing strategies to address eligibility backlogs, including expanding ex parte determinations to ensure timely eligibility determinations and renewals.

(2) Initial reports shall be issued within 90 days after the effective date of this amendatory Act of the 101st General Assembly.

(3) All reports shall be published on the Department's website.

(i) It is the determination of the General Assembly that the Department must include seniors and persons with disabilities in ex parte renewals. It is the determination of the General Assembly that the Department must use its asset verification system to assist in the determination of whether an individual's coverage can be renewed using the ex parte process. If a State Plan amendment is required, the Department shall pursue such State Plan amendment by July 1, 2022. Within 60 days after receiving federal approval or guidance, the Department of Healthcare and Family Services and the Department of Human Services shall make necessary technical and rule changes to implement these changes to the

redetermination process.

(Source: P.A. 101-209, eff. 8-5-19; 101-649, eff. 7-7-20; 102-1037, eff. 6-2-22.)

(305 ILCS 5/11-5.4)

Sec. 11-5.4. Expedited long-term care eligibility determination and enrollment.

(a) Establishment of the expedited long-term care eligibility determination and enrollment system shall be a joint venture of the Departments of Human Services and Healthcare and Family Services and the Department on Aging.

(b) Streamlined application enrollment process; expedited eligibility process. The streamlined application and enrollment process must include, but need not be limited to, the following:

(1) On or before July 1, 2019, a streamlined application and enrollment process shall be put in place which must include, but need not be limited to, the following:

(A) Minimize the burden on applicants by collecting only the data necessary to determine eligibility for medical services, long-term care services, and spousal impoverishment offset.

(B) Integrate online data sources to simplify the application process by reducing the amount of information needed to be entered and to expedite

eligibility verification.

(C) Provide online prompts to alert the applicant that information is missing or not complete.

(D) Provide training and step-by-step written instructions for caseworkers, applicants, and providers.

(2) The State must expedite the eligibility process for applicants meeting specified guidelines, regardless of the age of the application. The guidelines, subject to federal approval, must include, but need not be limited to, the following individually or collectively:

(A) Full Medicaid benefits in the community for a specified period of time.

(B) No transfer of assets or resources during the federally prescribed look-back period, as specified in federal law.

(C) Receives Supplemental Security Income payments or was receiving such payments at the time of admission to a nursing facility.

(D) For applicants or recipients with verified income at or below 100% of the federal poverty level when the declared value of their countable resources is no greater than the allowable amounts pursuant to Section 5-2 of this Code for classes of eligible persons for whom a resource limit applies. Such simplified verification policies shall apply to

community cases as well as long-term care cases.

(3) Subject to federal approval, the Department of Healthcare and Family Services must implement an ex parte renewal process for Medicaid-eligible individuals residing in long-term care facilities. "Renewal" has the same meaning as "redetermination" in State policies, administrative rule, and federal Medicaid law. The ex parte renewal process must be fully operational on or before January 1, 2019. If an individual has transferred to another long-term care facility, any ~~annual~~ notice concerning redetermination of eligibility must be sent to the long-term care facility where the individual resides as well as to the individual.

(4) The Department of Human Services must use the standards and distribution requirements described in this subsection and in Section 11-6 for notification of missing supporting documents and information during all phases of the application process: initial, renewal, and appeal.

(c) The Department of Human Services must adopt policies and procedures to improve communication between long-term care benefits central office personnel, applicants and their representatives, and facilities in which the applicants reside. Such policies and procedures must at a minimum permit applicants and their representatives and the facility in which the applicants reside to speak directly to an individual trained to take telephone inquiries and provide appropriate

responses.

(d) Effective 30 days after the completion of 3 regionally based trainings, nursing facilities shall submit all applications for medical assistance online via the Application for Benefits Eligibility (ABE) website. This requirement shall extend to scanning and uploading with the online application any required additional forms such as the Long Term Care Facility Notification and the Additional Financial Information for Long Term Care Applicants as well as scanned copies of any supporting documentation. Long-term care facility admission documents must be submitted as required in Section 5-5 of this Code. No local Department of Human Services office shall refuse to accept an electronically filed application. No Department of Human Services office shall request submission of any document in hard copy.

(e) Notwithstanding any other provision of this Code, the Department of Human Services and the Department of Healthcare and Family Services' Office of the Inspector General shall, upon request, allow an applicant additional time to submit information and documents needed as part of a review of available resources or resources transferred during the look-back period. The initial extension shall not exceed 30 days. A second extension of 30 days may be granted upon request. Any request for information issued by the State to an applicant shall include the following: an explanation of the information required and the date by which the information

must be submitted; a statement that failure to respond in a timely manner can result in denial of the application; a statement that the applicant or the facility in the name of the applicant may seek an extension; and the name and contact information of a caseworker in case of questions. Any such request for information shall also be sent to the facility. In deciding whether to grant an extension, the Department of Human Services or the Department of Healthcare and Family Services' Office of the Inspector General shall take into account what is in the best interest of the applicant. The time limits for processing an application shall be tolled during the period of any extension granted under this subsection.

(f) The Department of Human Services and the Department of Healthcare and Family Services must jointly compile data on pending applications, denials, appeals, and redeterminations into a monthly report, which shall be posted on each Department's website for the purposes of monitoring long-term care eligibility processing. The report must specify the number of applications and redeterminations pending long-term care eligibility determination and admission and the number of appeals of denials in the following categories:

(A) Length of time applications, redeterminations, and appeals are pending - 0 to 45 days, 46 days to 90 days, 91 days to 180 days, 181 days to 12 months, over 12 months to 18 months, over 18 months to 24 months, and over 24 months.

(B) Percentage of applications and redeterminations

pending in the Department of Human Services' Family Community Resource Centers, in the Department of Human Services' long-term care hubs, with the Department of Healthcare and Family Services' Office of Inspector General, and those applications which are being tolled due to requests for extension of time for additional information.

(C) Status of pending applications, denials, appeals, and redeterminations.

(g) Beginning on July 1, 2017, the Auditor General shall report every 3 years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services, the Department of Human Services, and the Department on Aging in meeting the requirements of this Section and the federal requirements concerning eligibility determinations for Medicaid long-term care services and supports, and shall report any issues or deficiencies and make recommendations. The Auditor General shall, at a minimum, review, consider, and evaluate the following:

(1) compliance with federal regulations on furnishing services as related to Medicaid long-term care services and supports as provided under 42 CFR 435.930;

(2) compliance with federal regulations on the timely determination of eligibility as provided under 42 CFR 435.912;

(3) the accuracy and completeness of the report

required under paragraph (9) of subsection (e);

(4) the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of the Department of Human Services for long-term care services, including the role of the State's integrated eligibility system, as opposed to the traditional caseworker-specific process from which these central offices have converted; and

(5) any issues affecting eligibility determinations related to the Department of Human Services' staff completing Medicaid eligibility determinations instead of the designated single-state Medicaid agency in Illinois, the Department of Healthcare and Family Services.

The Auditor General's report shall include any and all other areas or issues which are identified through an annual review. Paragraphs (1) through (5) of this subsection shall not be construed to limit the scope of the annual review and the Auditor General's authority to thoroughly and completely evaluate any and all processes, policies, and procedures concerning compliance with federal and State law requirements on eligibility determinations for Medicaid long-term care services and supports.

(h) The Department of Healthcare and Family Services shall adopt any rules necessary to administer and enforce any provision of this Section. Rulemaking shall not delay the full implementation of this Section.

(i) Beginning on June 29, 2018, provisional eligibility for medical assistance under Article V of this Code, in the form of a recipient identification number and any other necessary credentials to permit an applicant to receive covered services under Article V, must be issued to any applicant who has not received a determination on his or her application for Medicaid and Medicaid long-term care services filed simultaneously or, if already Medicaid enrolled, application for Medicaid long-term care services under Article V of this Code within the federally prescribed timeliness requirements for determinations on such applications. The Department of Healthcare and Family Services must maintain the applicant's provisional eligibility status until a determination is made on the individual's application for long-term care services. The Department of Healthcare and Family Services or the managed care organization, if applicable, must reimburse providers for services rendered during an applicant's provisional eligibility period.

(1) Claims for services rendered to an applicant with provisional eligibility status must be submitted and processed in the same manner as those submitted on behalf of beneficiaries determined to qualify for benefits.

(2) An applicant with provisional eligibility status must have his or her long-term care benefits paid for under the State's fee-for-service system during the period of provisional eligibility. If an individual otherwise

eligible for medical assistance under Article V of this Code is enrolled with a managed care organization for community benefits at the time the individual's provisional eligibility for long-term care services is issued, the managed care organization is only responsible for paying benefits covered under the capitation payment received by the managed care organization for the individual.

(3) The Department of Healthcare and Family Services, within 10 business days of issuing provisional eligibility to an applicant, must submit to the Office of the Comptroller for payment a voucher for all retroactive reimbursement due. The Department of Healthcare and Family Services must clearly identify such vouchers as provisional eligibility vouchers.

(Source: P.A. 101-101, eff. 1-1-20; 101-209, eff. 8-5-19; 101-265, eff. 8-9-19; 101-559, eff. 8-23-19; 102-558, eff. 8-20-21.)

ARTICLE 225.

Section 225-5. The Illinois Act on the Aging is amended by changing Section 4.02 as follows:

(20 ILCS 105/4.02)

Sec. 4.02. Community Care Program. The Department shall

establish a program of services to prevent unnecessary institutionalization of persons age 60 and older in need of long term care or who are established as persons who suffer from Alzheimer's disease or a related disorder under the Alzheimer's Disease Assistance Act, thereby enabling them to remain in their own homes or in other living arrangements. Such preventive services, which may be coordinated with other programs for the aged, may include, but are not limited to, any or all of the following:

(a) (blank);

(b) (blank);

(c) home care aide services;

(d) personal assistant services;

(e) adult day services;

(f) home-delivered meals;

(g) education in self-care;

(h) personal care services;

(i) adult day health services;

(j) habilitation services;

(k) respite care;

(k-5) community reintegration services;

(k-6) flexible senior services;

(k-7) medication management;

(k-8) emergency home response;

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

(m) (blank).

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

The Department shall require as a condition of eligibility that all new financially eligible applicants apply for and enroll in medical assistance under Article V of the Illinois Public Aid Code in accordance with rules promulgated by the Department.

The Department shall, in conjunction with the Department of Public Aid (now Department of Healthcare and Family Services), seek appropriate amendments under Sections 1915 and 1924 of the Social Security Act. The purpose of the amendments shall be to extend eligibility for home and community based services under Sections 1915 and 1924 of the Social Security Act to persons who transfer to or for the benefit of a spouse those amounts of income and resources allowed under Section 1924 of the Social Security Act. Subject to the approval of such amendments, the Department shall extend the provisions of

Section 5-4 of the Illinois Public Aid Code to persons who, but for the provision of home or community-based services, would require the level of care provided in an institution, as is provided for in federal law. Those persons no longer found to be eligible for receiving noninstitutional services due to changes in the eligibility criteria shall be given 45 days notice prior to actual termination. Those persons receiving notice of termination may contact the Department and request the determination be appealed at any time during the 45 day notice period. The target population identified for the purposes of this Section are persons age 60 and older with an identified service need. Priority shall be given to those who are at imminent risk of institutionalization. The services shall be provided to eligible persons age 60 and older to the extent that the cost of the services together with the other personal maintenance expenses of the persons are reasonably related to the standards established for care in a group facility appropriate to the person's condition. These noninstitutional services, pilot projects, or experimental facilities may be provided as part of or in addition to those authorized by federal law or those funded and administered by the Department of Human Services. The Departments of Human Services, Healthcare and Family Services, Public Health, Veterans' Affairs, and Commerce and Economic Opportunity and other appropriate agencies of State, federal, and local governments shall cooperate with the Department on Aging in

the establishment and development of the noninstitutional services. The Department shall require an annual audit from all personal assistant and home care aide vendors contracting with the Department under this Section. The annual audit shall assure that each audited vendor's procedures are in compliance with Department's financial reporting guidelines requiring an administrative and employee wage and benefits cost split as defined in administrative rules. The audit is a public record under the Freedom of Information Act. The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department of Healthcare and Family Services, to effect the following: (1) intake procedures and common eligibility criteria for those persons who are receiving noninstitutional services; and (2) the establishment and development of noninstitutional services in areas of the State where they are not currently available or are undeveloped. On and after July 1, 1996, all nursing home prescreenings for individuals 60 years of age or older shall be conducted by the Department.

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

The Department is authorized to establish a system of recipient copayment for services provided under this Section, such copayment to be based upon the recipient's ability to pay but in no case to exceed the actual cost of the services provided. Additionally, any portion of a person's income which is equal to or less than the federal poverty standard shall not be considered by the Department in determining the copayment. The level of such copayment shall be adjusted whenever necessary to reflect any change in the officially designated federal poverty standard.

The Department, or the Department's authorized representative, may recover the amount of moneys expended for services provided to or in behalf of a person under this Section by a claim against the person's estate or against the estate of the person's surviving spouse, but no recovery may be had until after the death of the surviving spouse, if any, and then only at such time when there is no surviving child who is under age 21 or blind or who has a permanent and total disability. This paragraph, however, shall not bar recovery, at the death of the person, of moneys for services provided to the person or in behalf of the person under this Section to which the person was not entitled; provided that such recovery shall not be enforced against any real estate while it is occupied as a homestead by the surviving spouse or other dependent, if no claims by other creditors have been filed against the estate, or, if such claims have been filed, they

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

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

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

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

(3) ensuring that the participants have the right to

choose the services contained in their care plan and to direct how those services are provided, based on administrative rules established by the Department;

(4)(blank);

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

(A) bathing;

(B) grooming;

(C) toileting;

(D) nail care;

(E) transferring;

(F) respiratory services;

(G) exercise; or

(H) positioning;

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

(7) ensuring that the State may access maximum federal matching funds by seeking approval for the Centers for Medicare and Medicaid Services for modifications to the State's home and community based services waiver and additional waiver opportunities, including applying for

enrollment in the Balance Incentive Payment Program by May 1, 2013, in order to maximize federal matching funds; this shall include, but not be limited to, modification that reflects all changes in the Community Care Program services and all increases in the services cost maximum;

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

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

(10) working in conjunction with Care Coordination Units, the Department of Healthcare and Family Services, the Department of Human Services, Community Care Program providers, and other stakeholders to make improvements to the Medicaid claiming processes and the Medicaid enrollment procedures or requirements as needed, including, but not limited to, specific policy changes or rules to improve the up-front enrollment of participants in the Medicaid program and specific policy changes or

rules to ensure ~~insure~~ more prompt submission of bills to the federal government to secure maximum federal matching dollars as promptly as possible; the Department on Aging shall have at least 3 meetings with stakeholders by January 1, 2014 in order to address these improvements;

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

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

(13) (blank).

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

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

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

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

The Community Care Program Advisory Committee is created in the Department on Aging. The Director shall appoint individuals to serve in the Committee, who shall serve at their own expense. Members of the Committee must abide by all applicable ethics laws. The Committee shall advise the Department on issues related to the Department's program of services to prevent unnecessary institutionalization. The Committee shall meet on a bi-monthly basis and shall serve to identify and advise the Department on present and potential issues affecting the service delivery network, the program's clients, and the Department and to recommend solution strategies. Persons appointed to the Committee shall be appointed on, but not limited to, their own and their agency's experience with the program, geographic representation, and willingness to serve. The Director shall appoint members to the Committee to represent provider, advocacy, policy research, and other constituencies committed to the delivery

of high quality home and community-based services to older adults. Representatives shall be appointed to ensure representation from community care providers, including, but not limited to, adult day service providers, homemaker providers, case coordination and case management units, emergency home response providers, statewide trade or labor unions that represent home care aides and direct care staff, area agencies on aging, adults over age 60, membership organizations representing older adults, and other organizational entities, providers of care, or individuals with demonstrated interest and expertise in the field of home and community care as determined by the Director.

Nominations may be presented from any agency or State association with interest in the program. The Director, or his or her designee, shall serve as the permanent co-chair of the advisory committee. One other co-chair shall be nominated and approved by the members of the committee on an annual basis. Committee members' terms of appointment shall be for 4 years with one-quarter of the appointees' terms expiring each year. A member shall continue to serve until his or her replacement is named. The Department shall fill vacancies that have a remaining term of over one year, and this replacement shall occur through the annual replacement of expiring terms. The Director shall designate Department staff to provide technical assistance and staff support to the committee. Department representation shall not constitute membership of the

committee. All Committee papers, issues, recommendations, reports, and meeting memoranda are advisory only. The Director, or his or her designee, shall make a written report, as requested by the Committee, regarding issues before the Committee.

The Department on Aging and the Department of Human Services shall cooperate in the development and submission of an annual report on programs and services provided under this Section. Such joint report shall be filed with the Governor and the General Assembly on or before March 31 of the following fiscal year.

The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act and filing 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.

Those persons previously found eligible for receiving noninstitutional services whose services were discontinued under the Emergency Budget Act of Fiscal Year 1992, and who do not meet the eligibility standards in effect on or after July 1, 1992, shall remain ineligible on and after July 1, 1992. Those persons previously not required to cost-share and who were required to cost-share effective March 1, 1992, shall continue to meet cost-share requirements on and after July 1, 1992. Beginning July 1, 1992, all clients will be required to

meet eligibility, cost-share, and other requirements and will have services discontinued or altered when they fail to meet these requirements.

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

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

The Department shall require, as a condition of eligibility, application for the medical assistance program under Article V of the Illinois Public Aid Code.

The Department may authorize Community Care Program services until an applicant is determined eligible for medical assistance under Article V of the Illinois Public Aid Code.

The Department shall continue to provide Community Care Program reports as required by statute, which shall include an annual report on Care Coordination Unit performance and adherence to service guidelines and a 6-month supplemental report.

In regard to community care providers, failure to comply with Department on Aging policies shall be cause for disciplinary action, including, but not limited to,

disqualification from serving Community Care Program clients. Each provider, upon submission of any bill or invoice to the Department for payment for services rendered, shall include a notarized statement, under penalty of perjury pursuant to Section 1-109 of the Code of Civil Procedure, that the provider has complied with all Department policies.

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

The Department shall pay an enhanced rate of at least $1.77 per unit under the Community Care Program to those in-home service provider agencies that offer health insurance coverage as a benefit to their direct service worker employees pursuant to rules adopted by the Department. The Department shall review the enhanced rate as part of its process to rebase in-home service provider reimbursement rates pursuant to federal waiver requirements. Subject to federal approval, beginning on January 1, 2024, rates for adult day services shall be increased to $16.84 per hour and rates for each way transportation services for adult day services shall be increased to $12.44 per unit transportation.

Subject to federal approval, on and after January 1, 2024, rates for homemaker services shall be increased to $28.07 to sustain a minimum wage of $17 per hour for direct service

workers. Rates in subsequent State fiscal years shall be no lower than the rates put into effect upon federal approval. Providers of in-home services shall be required to certify to the Department that they remain in compliance with the mandated wage increase for direct service workers. Fringe benefits, including, but not limited to, paid time off and payment for training, health insurance, travel, or transportation, shall not be reduced in relation to the rate increases described in this paragraph.

Subject to and upon federal approval, on and after January 1, 2025, rates for homemaker services shall be increased to $29.63 to sustain a minimum wage of $18 per hour for direct service workers. Rates in subsequent State fiscal years shall be no lower than the rates put into effect upon federal approval. Providers of in-home services shall be required to certify to the Department that they remain in compliance with the mandated wage increase for direct service workers. Fringe benefits, including, but not limited to, paid time off and payment for training, health insurance, travel, or transportation, shall not be reduced in relation to the rate increases described in this paragraph.

Subject to and upon federal approval, on and after January 1, 2026, rates for homemaker services shall be increased to $30.80 to sustain a minimum wage of $18.75 per hour for direct service workers. Rates in subsequent State fiscal years shall be no lower than the rates put into effect upon federal

approval. Providers of in-home services shall be required to certify to the Department that they remain in compliance with the mandated wage increase for direct service workers. Fringe benefits, including, but not limited to, paid time off and payment for training, health insurance, travel, or transportation, shall not be reduced in relation to the rate increases described in this paragraph.

The General Assembly finds it necessary to authorize an aggressive Medicaid enrollment initiative designed to maximize federal Medicaid funding for the Community Care Program which produces significant savings for the State of Illinois. The Department on Aging shall establish and implement a Community Care Program Medicaid Initiative. Under the Initiative, the Department on Aging shall, at a minimum: (i) provide an enhanced rate to adequately compensate care coordination units to enroll eligible Community Care Program clients into Medicaid; (ii) use recommendations from a stakeholder committee on how best to implement the Initiative; and (iii) establish requirements for State agencies to make enrollment in the State's Medical Assistance program easier for seniors.

The Community Care Program Medicaid Enrollment Oversight Subcommittee is created as a subcommittee of the Older Adult Services Advisory Committee established in Section 35 of the Older Adult Services Act to make recommendations on how best to increase the number of medical assistance recipients who are enrolled in the Community Care Program. The Subcommittee

shall consist of all of the following persons who must be appointed within 30 days after June 4, 2018 (the effective date of Public Act 100-587):

(1) The Director of Aging, or his or her designee, who shall serve as the chairperson of the Subcommittee.

(2) One representative of the Department of Healthcare and Family Services, appointed by the Director of Healthcare and Family Services.

(3) One representative of the Department of Human Services, appointed by the Secretary of Human Services.

(4) One individual representing a care coordination unit, appointed by the Director of Aging.

(5) One individual from a non-governmental statewide organization that advocates for seniors, appointed by the Director of Aging.

(6) One individual representing Area Agencies on Aging, appointed by the Director of Aging.

(7) One individual from a statewide association dedicated to Alzheimer's care, support, and research, appointed by the Director of Aging.

(8) One individual from an organization that employs persons who provide services under the Community Care Program, appointed by the Director of Aging.

(9) One member of a trade or labor union representing persons who provide services under the Community Care Program, appointed by the Director of Aging.

(10) One member of the Senate, who shall serve as co-chairperson, appointed by the President of the Senate.

(11) One member of the Senate, who shall serve as co-chairperson, appointed by the Minority Leader of the Senate.

(12) One member of the House of Representatives, who shall serve as co-chairperson, appointed by the Speaker of the House of Representatives.

(13) One member of the House of Representatives, who shall serve as co-chairperson, appointed by the Minority Leader of the House of Representatives.

(14) One individual appointed by a labor organization representing frontline employees at the Department of Human Services.

The Subcommittee shall provide oversight to the Community Care Program Medicaid Initiative and shall meet quarterly. At each Subcommittee meeting the Department on Aging shall provide the following data sets to the Subcommittee: (A) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program and are enrolled in the State's Medical Assistance Program; (B) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program, but are not enrolled in the State's Medical Assistance Program; and (C) the number of Illinois residents, categorized by planning and

service area, who are receiving services under the Community Care Program and are eligible for benefits under the State's Medical Assistance Program, but are not enrolled in the State's Medical Assistance Program. In addition to this data, the Department on Aging shall provide the Subcommittee with plans on how the Department on Aging will reduce the number of Illinois residents who are not enrolled in the State's Medical Assistance Program but who are eligible for medical assistance benefits. The Department on Aging shall enroll in the State's Medical Assistance Program those Illinois residents who receive services under the Community Care Program and are eligible for medical assistance benefits but are not enrolled in the State's Medicaid Assistance Program. The data provided to the Subcommittee shall be made available to the public via the Department on Aging's website.

The Department on Aging, with the involvement of the Subcommittee, shall collaborate with the Department of Human Services and the Department of Healthcare and Family Services on how best to achieve the responsibilities of the Community Care Program Medicaid Initiative.

The Department on Aging, the Department of Human Services, and the Department of Healthcare and Family Services shall coordinate and implement a streamlined process for seniors to access benefits under the State's Medical Assistance Program.

The Subcommittee shall collaborate with the Department of Human Services on the adoption of a uniform application

submission process. The Department of Human Services and any other State agency involved with processing the medical assistance application of any person enrolled in the Community Care Program shall include the appropriate care coordination unit in all communications related to the determination or status of the application.

The Community Care Program Medicaid Initiative shall provide targeted funding to care coordination units to help seniors complete their applications for medical assistance benefits. On and after July 1, 2019, care coordination units shall receive no less than $200 per completed application, which rate may be included in a bundled rate for initial intake services when Medicaid application assistance is provided in conjunction with the initial intake process for new program participants.

The Community Care Program Medicaid Initiative shall cease operation 5 years after June 4, 2018 (the effective date of Public Act 100-587), after which the Subcommittee shall dissolve.

Effective July 1, 2023 <u>through June 30, 2026</u>, subject to federal approval, the Department on Aging shall reimburse Care Coordination Units at the following rates for case management services: $252.40 for each initial assessment; $366.40 for each initial assessment with translation; $229.68 for each redetermination assessment; $313.68 for each redetermination assessment with translation; $200.00 for each completed

application for medical assistance benefits; $132.26 for each face-to-face, choices-for-care screening; $168.26 for each face-to-face, choices-for-care screening with translation; $124.56 for each 6-month, face-to-face visit; $132.00 for each MCO participant eligibility determination; and $157.00 for each MCO participant eligibility determination with translation.

Effective July 1, 2026, subject to federal approval, the Department on Aging shall reimburse Care Coordination Units at the following rates for case management services: $252.40 for each initial assessment; $366.40 for each initial assessment with translation; $229.68 for each redetermination assessment; $313.68 for each redetermination assessment with translation; $200.00 for each completed application for medical assistance benefits; $132.26 for each face-to-face, choices-for-care screening; $168.26 for each face-to-face, choices-for-care screening with translation; $124.56 for each 6-month, face-to-face visit; $172 for each managed care participant eligibility determination; $197.00 for each managed care participant eligibility determination with translation; and $90 for each administration of a participant transfer from non-managed care CCP to managed care CCP or from managed care CCP to non-managed care CCP.

(Source: P.A. 103-8, eff. 6-7-23; 103-102, Article 45, Section 45-5, eff. 1-1-24; 103-102, Article 85, Section 85-5, eff. 1-1-24; 103-102, Article 90, Section 90-5, eff. 1-1-24;

103-588, eff. 6-5-24; 103-605, eff. 7-1-24; 103-670, eff. 1-1-25; 104-2, eff. 6-16-25; 104-417, eff. 8-15-25.)

ARTICLE 230.

Section 230-5. The Specialized Mental Health Rehabilitation Act of 2013 is amended by changing Sections 5-107 and 5-113 and by adding Section 5-114 as follows:

(210 ILCS 49/5-107)

Sec. 5-107. Quality of life enhancement. Beginning on July 1, 2019, for improving the quality of life and the quality of care, an additional payment shall be awarded to a facility for their single occupancy rooms. This payment shall be in addition to the rate for recovery and rehabilitation. The additional rate for single room occupancy shall be no less than $10 per day, per single room occupancy. The Department of Healthcare and Family Services shall adjust payment to Medicaid managed care entities to cover these costs. Beginning July 1, 2022, for improving the quality of life and the quality of care, a payment of no less than $5 per day, per single room occupancy shall be added to the existing $10 additional per day, per single room occupancy rate for a total of at least $15 per day, per single room occupancy. For improving the quality of life and the quality of care, on January 1, 2024, a payment of no less than $10.50 per day, per single room occupancy shall

be added to the existing $15 additional per day, per single room occupancy rate for a total of at least $25.50 per day, per single room occupancy. For improving the quality of life and the quality of care, beginning on January 1, 2025, a payment of no less than $10 per day, per single room occupancy shall be added to the existing $25.50 additional per day, per single room occupancy rate for a total of at least $35.50 per day, per single room occupancy. For improving the quality of life and the quality of care, beginning on July 1, 2026, a payment of no less than $8 per day, per single room occupancy shall be added to the existing $35.50 additional per day, per single room occupancy rate for a total of at least $43.50 per day, per single room occupancy. Beginning July 1, 2022, for improving the quality of life and the quality of care, an additional payment shall be awarded to a facility for its dual-occupancy rooms. This payment shall be in addition to the rate for recovery and rehabilitation. The additional rate for dual-occupancy rooms shall be no less than $10 per day, per Medicaid-occupied bed, in each dual-occupancy room. Beginning January 1, 2024, for improving the quality of life and the quality of care, a payment of no less than $4.50 per day, per dual-occupancy room shall be added to the existing $10 additional per day, per dual-occupancy room rate for a total of at least $14.50, per Medicaid-occupied bed, in each dual-occupancy room. Beginning January 1, 2025, for improving the quality of life and the quality of care, a payment of no

less than $8.75 per day, per dual-occupancy room shall be added to the existing $14.50 additional per day, per dual-occupancy room rate for a total of at least $23.25, per Medicaid-occupied bed, in each dual-occupancy room. The Department of Healthcare and Family Services shall adjust payment to Medicaid managed care entities to cover these costs. Beginning July 1, 2026, for improving the quality of life and the quality of care, a payment of no less than $2.50 per day, per dual-occupancy room shall be added to the existing $23.25 additional per day, per dual-occupancy room rate for a total of at least $25.75, per Medicaid-occupied bed, in each dual-occupancy room. The Department of Healthcare and Family Services shall adjust payment to Medicaid managed care entities to cover these costs. As used in this Section, "dual-occupancy room" means a room that contains 2 resident beds.

(Source: P.A. 102-699, eff. 4-19-22; 103-102, eff. 1-1-24; 103-593, eff. 6-7-24.)

(210 ILCS 49/5-113)

Sec. 5-113. Specialized mental health rehabilitation facility; one payment. Notwithstanding any other provision of this Act to the contrary, beginning January 1, 2025, there shall be a separate per diem ~~add-on~~ paid solely and exclusively to facilities licensed under this Act that are licensed for only single occupancy rooms and have reduced

their licensed capacity. No facility licensed under this Act shall be eligible for these payments if the facility contains any rooms that house more than a single occupant and has ~~have~~ failed to reduce the facility's ~~facilities'~~ licensed capacity.

The payment shall be a per diem ~~add-on~~ payment. For facilities with less than 100 licensed beds, the ~~add-on~~ payment shall result in a rate not less than $240 per day. For facilities with 100 licensed beds to 130 licensed beds, the ~~add-on~~ payment shall result in a rate not less than $230 per day. For facilities with more than 130 licensed beds, the ~~add-on~~ payment shall result in a rate of not less than $220 per day. All ~~add-on~~ rates shall be based upon the new licensed capacity.

~~Any additional payments in effect after January 1, 2025 under Section 5-107 shall be paid in addition to the amounts listed in this Section.~~ Facilities receiving payments under this Section shall receive payment as prescribed under Section 5-101.

Beginning July 1, 2026, for facilities with less than 100 licensed beds, the payment shall result in a rate not less than $247.50 per day. Beginning July 1, 2026, for facilities with 100 licensed beds to 130 licensed beds, the payment shall result in a rate not less than $237.50 per day. For facilities with more than 130 beds, the payment shall result in a rate of no less than $225 per day.

(Source: P.A. 103-593, eff. 6-7-24.)

(210 ILCS 49/5-114 new)

Sec. 5-114. Forensic add-on payment. Notwithstanding any other provisions to the contrary, any facility that provides services to a resident found not guilty by reason of insanity and is thereby deemed unable to stand trial shall receive an additional payment of $15 per bed, per day for any resident found not guilty by reason of insanity and is thereby deemed unable to stand trial.

ARTICLE 235.

Section 235-5. The Department of Human Services Act is amended by adding Section 10-13 as follows:

(20 ILCS 1305/10-13 new)

Sec. 10-13. Pilot programs with local government entities, nonprofits, or privately funded programs. The Department of Human Services may, subject to appropriation, establish pilot programs through which financial and other support, provided by local governments, nonprofits, or privately funded programs, may be provided to Illinois residents through current or future distribution methods utilized and administered by the Department of Human Services.

ARTICLE 240.

Section 240-5. The Illinois Public Aid Code is amended by adding Section 5-54 as follows:

(305 ILCS 5/5-54 new)

Sec. 5-54. Coverage for proteomic blood tests.

(a) The medical assistance program shall provide coverage and reimbursement for a prescribed proteomic blood test, with clinical trial proof of improved infant outcomes published in peer-reviewed journals, that identifies and quantifies the risk of preterm birth for an individual pregnancy.

(b) The medical assistance program shall provide coverage and reimbursement for remote patient management services, including telecare management and remote physiologic monitoring, that address maternity and postpartum care access challenges for individualized care delivery by licensed providers. Only remote patient management services with evidence of improved patient care shall be covered and reimbursed under this subsection.

ARTICLE 245.

Section 245-5. The Illinois Public Aid Code is amended by adding Section 5-30.19 as follows:

(305 ILCS 5/5-30.19 new)

Sec. 5-30.19. MCO behavioral health post-payment reviews.

(a) In this Section:

"Extrapolated" shall be used as "extrapolation" is used in 89 Ill. Adm. Code 140.30(b) or any successor rule.

"Managed care organization" or "MCO" has the meaning given to that term in Section 5-30.1 of this Code.

"Post-payment review" means an examination that occurs after payment is made by an MCO for a selected claim to determine whether the initial determination for payment was appropriate.

"Provider" means a community mental health center, behavioral health clinic, certified community behavioral health clinic, or substance use treatment and recovery center that is enrolled in the medical assistance program and contracted with or reimbursed by an MCO.

(b) Beginning July 1, 2027, when conducting post-payment reviews of providers, MCOs must establish guidelines that follow the Department's guidance. The Department's guidance shall mandate that MCOs:

(1) Clearly define the documentation and the response time frames ensuring that all requests are directly tied to the review objectives. Documentation and response time frames do not apply to methods necessary for fraud, waste, and abuse post-payment reviews, including, but not limited to, unscheduled or unannounced site visits and database checks.

(2) Identify regulatory, statutory, or contractual authority and standards for conducting the post-payment review.

(3) Clearly define evaluation criteria and provide documentation checklists.

(4) Establish a process to dispute MCO record requests not made in conformance with this Section.

(5) Establish a process and clarify the instances that allow for entry and exit communications with providers to clearly convey the review scope, expectations, preliminary findings, compliance status, and next steps, ensuring consistent messaging throughout the review process.

(6) Establish qualifications of reviewers with relevant knowledge, experience, and training.

(7) Provide the data on how the provider varies significantly from other providers in the same provider type, service specialty, jurisdiction, or locality, if the basis for selection of a provider for review is comparative data except where fraud, waste, and abuse processes and procedures prevent disclosure.

(8) Clearly outline communication protocols, including advance written notice, delivered electronically, by MCOs to providers of documentation requests with an allowance for reasonable response times and except for instances where fraud, waste, and abuse processes and procedures prevent advance notice, including, but not limited to,

unscheduled or unannounced site visits.

(9) Upon completion of the review, issue a formal written notice of compliance or closure to the provider. The final review findings shall include clear references to applicable regulatory or contractual citations, an explanation of the rationale for each finding, guidance on required next steps or corrective actions, and information regarding the process and timelines for appealing the findings.

(10) Use the least burdensome and lowest-cost method of record submission, including secure electronic methods, when available. The date on which documentation is received in the electronic communication shall be the official date of receipt. All communication protocols shall be compliant with privacy and security laws.

(11) Issue findings and related written communications in a clear, consistent, and non-contradictory manner to prevent confusion or conflicting conclusions.

(12) Disclose the methodology supporting any extrapolated finding.

(c) The MCO shall post the guidelines and any updates on its publicly available website.

(d) Providers must not be subject to any adverse action, payment delay, sanctions, or contract termination solely for exercising the right to dispute a records request in accordance with this Section, except for matters involving

allegations of fraud, waste, or abuse.

(e) Nothing in this Section shall be construed to conflict with State or federal program integrity law, regulations, guidance, processes, or procedures.

ARTICLE 250.

Section 250-5. The Illinois Public Aid Code is amended by adding Section 5-70 as follows:

(305 ILCS 5/5-70 new)

Sec. 5-70. Virtual intensive outpatient program services. For dates of service on and after January 1, 2027, subject to any necessary federal approval, the medical assistance program shall provide coverage for virtual intensive outpatient program services when clinically appropriate, delivered in line with generally accepted standards of care, and only at the request of or with the consent of the patient. The Department shall establish provider qualifications for intensive outpatient program services offering a virtual service delivery option. The Department may establish utilization controls and any appropriate guidelines for coverage of the virtual intensive outpatient program to protect the well-being of persons eligible and enrolled in the medical assistance program. The Department may adopt rules necessary to implement this Section.

ARTICLE 255.

Section 255-5. The Illinois Public Aid Code is amended by changing Section 5-5.01a as follows:

(305 ILCS 5/5-5.01a)

Sec. 5-5.01a. Supportive living facilities program.

(a) The Department shall establish and provide oversight for a program of supportive living facilities that seek to promote resident independence, dignity, respect, and well-being in the most cost-effective manner.

A supportive living facility is (i) a free-standing facility or (ii) a distinct physical and operational entity within a mixed-use building that meets the criteria established in subsection (d). A supportive living facility integrates housing with health, personal care, and supportive services and is a designated setting that offers residents their own separate, private, and distinct living units.

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

(b) Beginning July 1, 2014, subject to federal approval, the Medicaid rates for supportive living facilities shall be equal to the supportive living facility Medicaid rate

effective on June 30, 2014 increased by 8.85%. Once the assessment imposed at Article V-G of this Code is determined to be a permissible tax under Title XIX of the Social Security Act, the Department shall increase the Medicaid rates for supportive living facilities effective on July 1, 2014 by 9.09%. The Department shall apply this increase retroactively to coincide with the imposition of the assessment in Article V-G of this Code in accordance with the approval for federal financial participation by the Centers for Medicare and Medicaid Services.

The Medicaid rates for supportive living facilities effective on July 1, 2017 must be equal to the rates in effect for supportive living facilities on June 30, 2017 increased by 2.8%.

The Medicaid rates for supportive living facilities effective on July 1, 2018 must be equal to the rates in effect for supportive living facilities on June 30, 2018.

Subject to federal approval, the Medicaid rates for supportive living services on and after July 1, 2019 must be at least 54.3% of the average total nursing facility services per diem for the geographic areas defined by the Department while maintaining the rate differential for dementia care and must be updated whenever the total nursing facility service per diems are updated. Beginning July 1, 2022, upon the implementation of the Patient Driven Payment Model, Medicaid rates for supportive living services must be at least 54.3% of

the average total nursing services per diem rate for the geographic areas. For purposes of this provision, the average total nursing services per diem rate shall include all add-ons for nursing facilities for the geographic area provided for in Section 5-5.2. The rate differential for dementia care must be maintained in these rates and the rates shall be updated whenever nursing facility per diem rates are updated.

Subject to federal approval, beginning January 1, 2024, the dementia care rate for supportive living services must be no less than the non-dementia care supportive living services rate multiplied by 1.5.

(b-5) Subject to federal approval, beginning January 1, 2025, Medicaid rates for supportive living services must be at least 54.75% of the average total nursing facility per diem rate for the geographic areas defined by the Department and shall include all add-ons for nursing facilities for the geographic area provided for in Section 5-5.2.

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

(d) Subject to federal approval by the Centers for Medicare and Medicaid Services, the Department shall accept

for consideration of certification under the program any application for a site or building where distinct parts of the site or building are designated for purposes other than the provision of supportive living services, but only if:

(1) those distinct parts of the site or building are not designated for the purpose of providing assisted living services as required under the Assisted Living and Shared Housing Act;

(2) those distinct parts of the site or building are completely separate from the part of the building used for the provision of supportive living program services, including separate entrances;

(3) those distinct parts of the site or building do not share any common spaces with the part of the building used for the provision of supportive living program services; and

(4) those distinct parts of the site or building do not share staffing with the part of the building used for the provision of supportive living program services.

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

(f) Section 9817 of the American Rescue Plan Act of 2021 (Public Law 117-2) authorizes a 10% enhanced federal medical

assistance percentage for supportive living services for a 12-month period from April 1, 2021 through March 31, 2022. Subject to federal approval, including the approval of any necessary waiver amendments or other federally required documents or assurances, for a 12-month period the Department must pay a supplemental $26 per diem rate to all supportive living facilities with the additional federal financial participation funds that result from the enhanced federal medical assistance percentage from April 1, 2021 through March 31, 2022. The Department may issue parameters around how the supplemental payment should be spent, including quality improvement activities. The Department may alter the form, methods, or timeframes concerning the supplemental per diem rate to comply with any subsequent changes to federal law, changes made by guidance issued by the federal Centers for Medicare and Medicaid Services, or other changes necessary to receive the enhanced federal medical assistance percentage.

(g) All applications for the expansion of supportive living dementia care settings involving sites not approved by the Department by January 1, 2024 may allow new elderly non-dementia units in addition to new dementia care units. The Department may approve such applications only if the application has: (1) no more than one non-dementia care unit for each dementia care unit and (2) the site is not located within 4 miles of an existing supportive living program site in Cook County (including the City of Chicago), not located

within 12 miles of an existing supportive living program site in Alexander, Bond, Boone, Calhoun, Champaign, Clinton, DeKalb, DuPage, Fulton, Grundy, Henry, Jackson, Jersey, Johnson, Kane, Kankakee, Kendall, Lake, Macon, Macoupin, Madison, Marshall, McHenry, McLean, Menard, Mercer, Monroe, Peoria, Piatt, Rock Island, Sangamon, Stark, St. Clair, Tazewell, Vermilion, Will, Williamson, Winnebago, or Woodford counties, or not located within 25 miles of an existing supportive living program site in any other county.

(g-5) Subject to federal approval, beginning January 1, 2027, any individual age 44 to 64 who is diagnosed as having Alzheimer's disease or a related dementia and is determined to be a person with a disability by the Social Security Administration shall be eligible for services in a supportive living dementia care setting if the individual meets all other eligibility requirements to receive services in a supportive living dementia care setting under 89 Ill. Adm. Code 146 Subpart B and E. The Department shall apply for any federal waiver necessary to implement this subsection.

(h) Beginning January 1, 2025, subject to federal approval, for a person who is a resident of a supportive living facility under this Section, the monthly personal needs allowance shall be $120 per month.

(i) As stated in the supportive living program home and community-based service waiver approved by the federal Centers for Medicare and Medicaid Services, and beginning July 1,

2025, the Department must maintain the rate add-on implemented on January 1, 2023 for the provision of 2 meals per day at no less than $6.15 per day.

(j) Subject to federal approval, the Department shall allow a certified medication aide to administer medication in a supportive living facility. For purposes of this subsection, "certified medication aide" means a person who has met the qualifications for certification under Section 79 of the Assisted Living and Shared Housing Act and assists with medication administration while under the supervision of a registered professional nurse as authorized by Section 50-75 of the Nurse Practice Act. The Department may adopt rules to implement this subsection.

(Source: P.A. 103-102, Article 20, Section 20-5, eff. 1-1-24; 103-102, Article 100, Section 100-5, eff. 1-1-24; 103-593, Article 15, Section 15-5, eff. 6-7-24; 103-593, Article 100, Section 100-5, eff. 6-7-24; 103-593, Article 165, Section 165-5, eff. 6-7-24; 103-605, eff. 7-1-24; 103-886, eff. 8-9-24; 104-9, eff. 6-16-25; 104-417, eff. 8-15-25; revised 9-12-25.)

ARTICLE 257.

Section 257-3. The Department of Public Health Powers and Duties Law is amended by adding Section 2310-716 as follows:

(20 ILCS 2310/2310-716 new)

Sec. 2310-716. Report on patient access and care. With a health care landscape shifting dramatically from inpatient, volume-drive care to more outpatient, community-faced care and further exacerbated by HR1 changes that disinvests billions of dollars from the health care system and increase uninsured populations, the Department of Public Health, in partnership with relevant State agencies and with the advice of stakeholders and experts in the field, shall develop a comprehensive report that identifies how the resources of the State and other health care payers may be optimized to protect communities' and patients' access and care and to improve Illinois' population health outcomes.

The Department may engage a third-party experienced and expert research entity to develop this report. The report shall include analysis, findings, and recommendations to reform and strengthen the health care system in Illinois. The report will have emphasis on the needs and vulnerabilities experienced by individuals living in communities with limited access to critical health care services.

The report will include epidemiological analyses and recommendations on policy and resource strategies to protect and improve population health outcomes and health care access including but not limited to:

(1) Patient experience that includes social needs integration, reduced administrative burden, and enhanced

digital tools.

(2) Care model transformation that emphasizes continuous, community-based care built to address health access gaps and needs.

(3) Workforce resilience and optimization that highlights partnership and care-delivery opportunities across institutions.

(4) System agility to absorb and recover from unforeseen public health crises and other external factors.

The Department shall have access to all the necessary data from State agencies as well as health care facilities as required to inform on these recommendations, within the bounds of relevance to their mission. Health care facilities will hereby be directed to provide the necessary data to the Department.

The Department shall issue recommendations to the General Assembly and the Governor no later than January 31, 2027, including proposed statutory or administrative changes necessary to strengthen health care access, quality, and effectiveness.

(20 ILCS 2310/2310-715 rep.)

Section 257-5. The Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois is amended by repealing Section 2310-715.

Section 257-10. The Illinois Public Aid Code is amended by changing Sections 5A-2, 5A-7, 5A-8, and 12-4.25 as follows:

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

Sec. 5A-2. Assessment.

(a)(1) Subject to Sections 5A-3 and 5A-10, for State fiscal years 2009 through 2018, or as long as continued under Section 5A-16, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided, however, that the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the State share of the payments authorized under Section 5A-12.5, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period of April through June 2015, the amount of $218.38 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $20,250,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually

thereafter through June 2018, or as provided in Section 5A-16, in addition to any federally required State share as authorized under paragraph (1), the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

For State fiscal years 2009 through 2018, or as provided in Section 5A-16, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.

(3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $197.19 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed

days. For State fiscal years 2019 and 2020, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

(4) Subject to Sections 5A-3 and 5A-10 and to subsection (b-8), for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2024, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $221.50 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided however: for the period of July 1, 2020 through

December 31, 2020, (i) the assessment shall be equal to 50% of the annual amount; and (ii) the amount of $221.50 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment, as defined in subsection (b-7). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2024, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Should the change in the assessment methodology for fiscal years 2021 through December 31, 2022 not be approved on or before June 30, 2020, the assessment and payments under this Article in effect for fiscal year 2020 shall remain in place until the new assessment is approved. If the assessment methodology for July 1, 2020 through December 31, 2022, is approved on or after July

1, 2020, it shall be retroactive to July 1, 2020, subject to federal approval and provided that the payments authorized under Section 5A-12.7 have the same effective date as the new assessment methodology. In giving retroactive effect to the assessment approved after June 30, 2020, credit toward the new assessment shall be given for any payments of the previous assessment for periods after June 30, 2020. Notwithstanding any other provision of this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State Fiscal Year 2020 on the basis of hypothetical data, the data that was the basis for the 2020 assessment shall be used to calculate the assessment under this paragraph until December 31, 2023. Beginning July 1, 2022 and through December 31, 2024, a safety-net hospital that had a change of ownership in calendar year 2021, and whose inpatient utilization had decreased by 90% from the prior year and prior to the change of ownership, may be eligible to pay a tax based on hypothetical data based on a determination of financial distress by the Department. Subject to federal approval, the Department may, by January 1, 2024, develop a hypothetical tax for a specialty cancer hospital which had a structural change of ownership during calendar year 2022 from a for-profit entity to a non-profit entity, and which has experienced a decline of 60% or greater in inpatient days of care as compared to the prior owners 2015 Medicare cost report. This change of ownership may make the hospital

eligible for a hypothetical tax under the new hospital provision of the assessment defined in this Section. This new hypothetical tax may be applicable from January 1, 2024 through December 31, 2026.

(5) Subject to Sections 5A-3 and 5A-10, beginning January 1, 2025, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $362, or any reduction thereof in accordance with this subsection, multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days; however, the rate shall be $221.50 until the Department receives federal approval and implements the reimbursement rates in subsection (r) of Section 5A-12.7. The Department may bill for the difference between the assessment rate of $362, or any reduction thereof in accordance with this subsection, and $221.50 no earlier than 17 calendar days after implementing the reimbursement rates in subsection (r) of Section 5A-12.7.

(A) Upon receiving federal approval for the reimbursement rates in subsection (r) of Section 5A-12.7, the Department shall bill the hospital for the incremental difference in total tax due resulting from the increase provided in this subsection for the number of months from January 1, 2025 through the date of federal approval. The amount shall be due and payable no later than December 31, 2025 and no earlier than 17 calendar days after implementing the reimbursement rates in subsection (r) of

Section 5A-12.7. The Department shall bill hospitals in the same proportional rate as the Department has implemented the inpatient reimbursement rates in subsection (r) of Section 5A-12.7.

(B) Beginning January 1, 2025, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. If the reimbursement rates in subsection (r) of Section 5A-12.7 require reduction to comply with federal spending limits, then the tax rate of $362 shall be reduced, in accordance with subsection (s) of Section 5A-12.7, by the same percentage reduction to payments required to comply with federal spending limits.

(6) For calendar year 2026, and for each year thereafter

in which a tax is imposed under this Section, the Department may seek to obtain a waiver from the federal Centers for Medicare and Medicaid Services of the uniformity requirements in place for the tax imposed under this Section, provided that such waiver request does not risk the assessment imposed or payments authorized under this Section from continuing. Such uniformity requirements shall only be waived for not-for-profit hospitals operating as a freestanding cancer hospital that have contracted to provide services to members served by at least 50% of the managed care organizations contracted with the Department. Such tax rates imposed on a hospital shall be no more than 50% and no less than 25% of the tax imposed on all other hospitals in this State unless different rates are necessary to meet federal statistical tests necessary for continued federal financial participation. Upon federal approval of such a waiver, other tax rates imposed under this Article shall be adjusted to ensure budget neutrality.

(b) (Blank).

(b-5)(1) Subject to Sections 5A-3 and 5A-10, for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018, or as provided in Section 5A-16, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue, provided, however, that the amount

of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 5A-12.5, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days. For the period of April through June 2015, the amount of .008766 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $6,750,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually thereafter through June 2018, in addition to any federally required State share as authorized under paragraph (1), the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

For the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and State fiscal years 2013 through 2018, or as provided in Section 5A-16, a hospital's

outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on June 30, 2011, without regard to any subsequent adjustments or changes to such data. If a hospital's 2009 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

(3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01358 multiplied by the hospital's outpatient gross revenue. For State fiscal years 2019 and 2020, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited

to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

(4) Subject to Sections 5A-3 and 5A-10 and to subsection (b-8), for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2024, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01525 multiplied by the hospital's outpatient gross revenue, provided however: (i) for the period of July 1, 2020 through December 31, 2020, the assessment shall be equal to 50% of the annual amount; and (ii) the amount of .01525 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment, as defined in subsection (b-7). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2024, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a

hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's outpatient revenue data from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Should the change in the assessment methodology above for fiscal years 2021 through calendar year 2022 not be approved prior to July 1, 2020, the assessment and payments under this Article in effect for fiscal year 2020 shall remain in place until the new assessment is approved. If the change in the assessment methodology above for July 1, 2020 through December 31, 2022, is approved after June 30, 2020, it shall have a retroactive effective date of July 1, 2020, subject to federal approval and provided that the payments authorized under Section 12A-7 have the same effective date as the new assessment methodology. In giving retroactive effect to the assessment approved after June 30, 2020, credit toward the new assessment shall be given for any payments of the previous assessment for periods after June 30, 2020. Notwithstanding any other provision of this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State Fiscal Year 2020 on the basis of hypothetical data, the data that was the basis for the 2020 assessment shall be used to calculate the assessment under

this paragraph until December 31, 2023. Beginning July 1, 2022 and through December 31, 2024, a safety-net hospital that had a change of ownership in calendar year 2021, and whose inpatient utilization had decreased by 90% from the prior year and prior to the change of ownership, may be eligible to pay a tax based on hypothetical data based on a determination of financial distress by the Department.

(5) Subject to Sections 5A-3 and 5A-10, beginning January 1, 2025, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .03273, or any reduction thereof in accordance with this subsection, multiplied by the hospital's outpatient gross revenue; however the rate shall remain .01525, until the Department receives federal approval and implements the reimbursement rates of payment in subsection (r) of Section 5A-12.7. The Department may bill for the difference between the assessment multiplier of .03273 and .01525 no earlier than 17 calendar days after the first payment based on the reimbursement rates in subsection (r) of Section 5A-12.7.

(A) Upon receiving federal approval for the reimbursement rates in subsection (r) of Section 5A-12.7, the Department shall bill the hospital for the incremental difference in total tax due resulting from the increase provided in this subsection for the number of months from January 1, 2025 through the date of federal approval. The amount shall be due and payable no later than December 31,

2025 and no earlier than 17 calendar days after implementing the reimbursement rates in subsection (r) of Section 5A-12.7. The Department shall bill hospitals in the same proportional rate as the Department has implemented the outpatient reimbursement rates in subsection (r) of Section 5A-12.7.

(B) Beginning January 1, 2025, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient revenue data from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. If the reimbursement rates in subsection (r) of Section 5A-12.7 require reduction to comply with federal spending limits, then the tax rate of .03273 shall be reduced, in accordance with subsection (s) of Section 5A-12.7, by the same percentage reduction to payments required to comply with federal spending limits.

(6) For calendar year 2026, and for each year thereafter in which a tax is imposed under this Section, the Department may seek to obtain a waiver from the federal Centers for Medicare and Medicaid Services of the uniformity requirements in place for the tax imposed under this Section, provided that such waiver request does not risk the assessment imposed or payments authorized under this Section from continuing. Such uniformity requirements shall only be waived for not-for-profit hospitals operating as a freestanding cancer hospital that have contracted to provide services to members served by at least 50% of the managed care organizations contracted with the Department. Such tax rates imposed on a hospital shall be no more than 50% and no less than 25% of the tax imposed on all other hospitals in this State unless different rates are necessary to meet federal statistical tests necessary for continued federal financial participation. Upon federal approval of such a waiver, other tax rates imposed under this Article shall be adjusted to ensure budget neutrality.

(b-6)(1) As used in this Section, "ACA Assessment Adjustment" means:

(A) For the period of July 1, 2016 through December 31, 2016, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care

organizations for hospital services due and payable in the month of April 2016 multiplied by 6.

(B) For the period of January 1, 2017 through June 30, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2016 multiplied by 6, except that the amount calculated under this subparagraph (B) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period beginning July 1, 2016 through December 31, 2016 and the estimated payments due and payable in the month of April 2016 multiplied by 6 as described in subparagraph (A).

(C) For the period of July 1, 2017 through December 31, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of April 2017 multiplied by 6, except that the amount calculated under this subparagraph (C) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under

Section 5A-12.5 for the period beginning January 1, 2017 through June 30, 2017 and the estimated payments due and payable in the month of October 2016 multiplied by 6 as described in subparagraph (B).

(D) For the period of January 1, 2018 through June 30, 2018, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2017 multiplied by 6, except that:

(i) the amount calculated under this subparagraph (D) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period of July 1, 2017 through December 31, 2017 and the estimated payments due and payable in the month of April 2017 multiplied by 6 as described in subparagraph (C); and

(ii) the amount calculated under this subparagraph (D) shall be adjusted to include the product of .19125 multiplied by the sum of the fee-for-service payments, if any, estimated to be paid to hospitals under subsection (b) of Section 5A-12.5.

(2) The Department shall complete and apply a final reconciliation of the ACA Assessment Adjustment prior to June

30, 2018 to account for:

(A) any differences between the actual payments issued or scheduled to be issued prior to June 30, 2018 as authorized in Section 5A-12.5 for the period of January 1, 2018 through June 30, 2018 and the estimated payments due and payable in the month of October 2017 multiplied by 6 as described in subparagraph (D); and

(B) any difference between the estimated fee-for-service payments under subsection (b) of Section 5A-12.5 and the amount of such payments that are actually scheduled to be paid.

The Department shall notify hospitals of any additional amounts owed or reduction credits to be applied to the June 2018 ACA Assessment Adjustment. This is to be considered the final reconciliation for the ACA Assessment Adjustment.

(3) Notwithstanding any other provision of this Section, if for any reason the scheduled payments under subsection (b) of Section 5A-12.5 are not issued in full by the final day of the period authorized under subsection (b) of Section 5A-12.5, funds collected from each hospital pursuant to subparagraph (D) of paragraph (1) and pursuant to paragraph (2), attributable to the scheduled payments authorized under subsection (b) of Section 5A-12.5 that are not issued in full by the final day of the period attributable to each payment authorized under subsection (b) of Section 5A-12.5, shall be refunded.

(4) The increases authorized under paragraph (2) of subsection (a) and paragraph (2) of subsection (b-5) shall be limited to the federally required State share of the total payments authorized under Section 5A-12.5 if the sum of such payments yields an annualized amount equal to or less than $450,000,000, or if the adjustments authorized under subsection (t) of Section 5A-12.2 are found not to be actuarially sound; however, this limitation shall not apply to the fee-for-service payments described in subsection (b) of Section 5A-12.5.

(b-7)(1) As used in this Section, "Assessment Adjustment" means:

(A) For the period of July 1, 2020 through December 31, 2020, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (k) of Section 5A-12.7 attributable to the period, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the period.

(B) For each calendar quarter beginning January 1, 2021 through December 31, 2022, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (k) of Section 5A-12.7 attributable to the period, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the period.

(C) Beginning on January 1, 2023, and each subsequent

July 1 and January 1, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (j) and subsection (r) of Section 5A-12.7 attributable to the 6-month period immediately preceding the period to which the adjustment applies, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the 6-month period immediately preceding the period to which the adjustment applies.

(D) For the 6-month tax adjustment period beginning July 1, 2026, the Assessment Adjustment defined in subparagraph (C) of this paragraph (1) shall be half of the amount calculated under subparagraph (C) of this paragraph (1).

(2) The Department shall calculate and notify each hospital of the total Assessment Adjustment and any additional assessment owed by the hospital or refund owed to the hospital on either a semi-annual or annual basis. Such notice shall be issued at least 30 days prior to any period in which the assessment will be adjusted. Any additional assessment owed by the hospital or refund owed to the hospital shall be uniformly applied to the assessment owed by the hospital in monthly installments for the subsequent semi-annual period or calendar year. If no assessment is owed in the subsequent year, any amount owed by the hospital or refund due to the hospital, shall be paid in a lump sum. If the calculation that is computed under this Section could result in a decrease in the

Department's federal financial participation percentage for payments authorized under Section 5A-12.7, then the Department shall instead apply a uniform percentage reduction to the payment rates outlined in subsection (r) of Section 5A-12.7 for all classes as defined in subsections (g) and (h) of Section 5A-12.7 by an amount no more than necessary to maximize federal reimbursement.

(3) The Department shall publish all details of the Assessment Adjustment calculation performed each year on its website within 30 days of completing the calculation, and also submit the details of the Assessment Adjustment calculation as part of the Department's annual report to the General Assembly.

(b-8) Notwithstanding any other provision of this Article, the Department shall reduce the assessments imposed on each hospital under subsections (a) and (b-5) by the uniform percentage necessary to reduce the total assessment imposed on all hospitals by an aggregate amount of $240,000,000, with such reduction being applied by June 30, 2022. The assessment reduction required for each hospital under this subsection shall be forever waived, forgiven, and released by the Department.

(c) (Blank).

(d) Notwithstanding any of the other provisions of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section,

as authorized by Section 5-46.2 of the Illinois Administrative Procedure Act.

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois

Administrative Procedure Act.

(f) To provide for the expeditious and timely implementation of the changes made to this Section by Public Act 104-7 ~~this amendatory Act of the 104th General Assembly~~, the Department may adopt emergency rules as authorized by Section 5-45 of the Illinois Administrative Procedure Act. The adoption of emergency rules is deemed to be necessary for the public interest, safety, and welfare.

(Source: P.A. 103-102, eff. 1-1-24; 104-7, eff. 6-16-25; 104-9, eff. 6-16-25; revised 8-5-25.)

(305 ILCS 5/5A-7) (from Ch. 23, par. 5A-7)

Sec. 5A-7. Administration; enforcement provisions.

(a) The Illinois Department shall establish and maintain a listing of all hospital providers appearing in the licensing records of the Illinois Department of Public Health, which shall show each provider's name and principal place of business and the name and address of each hospital operated, conducted, or maintained by the provider in this State. The listing shall also include the monthly assessment amounts owed for each hospital and any unpaid assessment liability greater than 90 days delinquent. The Illinois Department shall administer and enforce this Article and collect the assessments and penalty assessments imposed under this Article using procedures employed in its administration of this Code generally. The Illinois Department, its Director, and every

hospital provider subject to assessment under this Article shall have the following powers, duties, and rights:

(1) The Illinois Department may initiate either administrative or judicial proceedings, or both, to enforce provisions of this Article. Administrative enforcement proceedings initiated hereunder shall be governed by the Illinois Department's administrative rules. Judicial enforcement proceedings initiated hereunder shall be governed by the rules of procedure applicable in the courts of this State.

(2) (Blank).

(3) Any unpaid assessment under this Article shall become a lien upon the assets of the hospital upon which it was assessed. If any hospital provider, outside the usual course of its business, sells or transfers the major part of any one or more of (A) the real property and improvements, (B) the machinery and equipment, or (C) the furniture or fixtures, of any hospital that is subject to the provisions of this Article, the seller or transferor shall pay the Illinois Department the amount of any assessment, assessment penalty, and interest (if any) due from it under this Article up to the date of the sale or transfer. The Illinois Department may, in its discretion, foreclose on such a lien, but shall do so in a manner that is consistent with Section 5e of the Retailers' Occupation Tax Act. If the seller or transferor fails to pay any

assessment, assessment penalty, and interest (if any) due, the purchaser or transferee of such asset shall be liable for the amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee or until the purchaser or transferee receives from the Illinois Department a certificate showing that such assessment, penalty, and interest have been paid or a certificate from the Illinois Department showing that no assessment, penalty, or interest is due from the seller or transferor under this Article.

(4) Payments under this Article are not subject to the Illinois Prompt Payment Act. Credits or refunds shall not bear interest.

(b) In addition to any other remedy provided for and without sending a notice of assessment liability, the Illinois Department shall collect an unpaid assessment by withholding, as payment of the assessment, reimbursements or other amounts otherwise payable by the Illinois Department to the hospital provider, including, but not limited to, payment amounts otherwise payable from a managed care organization performing

duties under contract with the Illinois Department. To the extent not prohibited by federal or State law, the Department may collect an unpaid assessment by offsetting or recouping, as payment of the assessment obligation, amounts otherwise payable by any State agency to the hospital provider, including, but not limited to, State grants and grant appropriations.

(1) The requirements of this subsection may be waived in instances when a disaster proclamation has been declared by the Governor. In such circumstances, a hospital must demonstrate temporary financial distress and establish an agreement with the Illinois Department specifying when repayment in full of all taxes owed will occur.

(2) The requirements of this subsection may be waived by the Illinois Department in instances when a hospital has entered into and remains in compliance with a repayment plan or a tax deferral plan. A repayment plan or tax deferral plan must be entered into no later than 30 days after notice of an unpaid assessment payment. Beginning July 1, 2026, the Illinois Department shall not enter into any new tax deferral plan with a hospital. A hospital may enter into a repayment plan with the Department that includes terms for repayment of the total amount owed over 72 months or less, repaid in equal payment increments. Payments shall begin within 30 days of

the signed agreement date. Hospitals with existing repayment agreements that were negotiated and remain in effect prior to June 1, 2026 may either adhere to the terms of their existing agreements or, alternatively, seek to amend the existing agreement's repayment period to 72 months or less from the date the new agreement is entered into. Renegotiated repayment plans shall include equal payment increments for the total amount owed over the period of the renegotiated agreement. Such renegotiated repayment agreements may only include amendments to (a) the length of the repayment period and (b) the payment increments, provided that the total amount to be repaid does not change from what remained unpaid under the original repayment agreement and any additional amounts owed. An existing repayment or tax deferral agreement cannot be amended more than once unless otherwise agreed upon by the Department. ~~No repayment plan may exceed a period of 36 months. No tax deferral plan may exceed a period of 6 months, and repayment after the end of a tax deferral plan shall not exceed 36 months.~~ Failure to remain in compliance with a repayment plan or tax deferral plan shall cause immediate termination of such plan unless there is prior written consent from the Illinois Department for a period of non-compliance.

(3) Beginning September 1, 2025, the Illinois Department shall immediately collect all overdue unpaid

assessments and penalties through the collection methods authorized under this Section, unless a repayment plan or tax deferral plan has already been agreed to ~~by September 1, 2025~~.

(4) For any unpaid assessments and penalties that are overdue as of the effective date of this amendatory Act of the 104th General Assembly ~~of House Bill 2771 of the 104th General Assembly~~, upon receipt of payment the Department may, at its discretion, transfer funds from the Hospital Provider Fund to the Healthcare Provider Relief Fund, provided that, at the time of each transfer, there are no outstanding assessment-related payments owed to hospitals that cannot be paid from resources remaining in the Hospital Provider Fund after the transfer.

(c) To provide for the expeditious and timely implementation of the changes made to this Section by this amendatory Act of the 104th General Assembly, the Department may adopt emergency rules as authorized by Section 5-45 of the Illinois Administrative Procedure Act. The adoption of emergency rules is deemed to be necessary for the public interest, safety, and welfare.

(Source: P.A. 104-2, eff. 6-16-25; 104-7, eff. 6-16-25.)

(305 ILCS 5/12-4.25) (from Ch. 23, par. 12-4.25)

Sec. 12-4.25. Medical assistance program; vendor participation.

(A) The Illinois Department may deny, suspend, or terminate the eligibility of any person, firm, corporation, association, agency, institution or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor, and may deny, suspend, or recover payments, if after reasonable notice and opportunity for a hearing the Illinois Department finds:

(a) Such vendor is not complying with the Department's policy or rules and regulations, or with the terms and conditions prescribed by the Illinois Department in its vendor agreement, which document shall be developed by the Department as a result of negotiations with each vendor category, including physicians, hospitals, long term care facilities, pharmacists, optometrists, podiatric physicians, and dentists setting forth the terms and conditions applicable to the participation of each vendor group in the program; or

(b) Such vendor has failed to keep or make available for inspection, audit or copying, after receiving a written request from the Illinois Department, such records regarding payments claimed for providing services. This section does not require vendors to make available patient records of patients for whom services are not reimbursed under this Code; or

(c) Such vendor has failed to furnish any information requested by the Department regarding payments for providing goods or services; or

(d) Such vendor has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the medical assistance program; or

(e) Such vendor has furnished goods or services to a recipient which are (1) in excess of need, (2) harmful, or (3) of grossly inferior quality, all of such determinations to be based upon competent medical judgment and evaluations; or

(f) The vendor; a person with management responsibility for a vendor; an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor; an owner of a sole proprietorship which is a vendor; or a partner in a partnership which is a vendor, either:

(1) was previously terminated, suspended, or excluded from participation in the Illinois medical assistance program, or was terminated, suspended, or excluded from participation in another state or federal medical assistance or health care program; or

(2) was a person with management responsibility for a vendor previously terminated, suspended, or

excluded from participation in the Illinois medical assistance program, or terminated, suspended, or excluded from participation in another state or federal medical assistance or health care program during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(3) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor previously terminated, suspended, or excluded from participation in the Illinois medical assistance program, or terminated, suspended, or excluded from participation in a state or federal medical assistance or health care program during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(4) was an owner of a sole proprietorship or partner of a partnership previously terminated, suspended, or excluded from participation in the Illinois medical assistance program, or terminated, suspended, or excluded from participation in a state or federal medical assistance or health care program during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(f-1) Such vendor has a delinquent debt owed to the

Illinois Department; or

(g) The vendor; a person with management responsibility for a vendor; an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor; an owner of a sole proprietorship which is a vendor; or a partner in a partnership which is a vendor, either:

(1) has engaged in practices prohibited by applicable federal or State law or regulation; or

(2) was a person with management responsibility for a vendor at the time that such vendor engaged in practices prohibited by applicable federal or State law or regulation; or

(3) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a vendor at the time such vendor engaged in practices prohibited by applicable federal or State law or regulation; or

(4) was an owner of a sole proprietorship or partner of a partnership which was a vendor at the time such vendor engaged in practices prohibited by applicable federal or State law or regulation; or

(h) The direct or indirect ownership of the vendor (including the ownership of a vendor that is a sole proprietorship, a partner's interest in a vendor that is a

partnership, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor) has been transferred by an individual who is terminated, suspended, or excluded or barred from participating as a vendor to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

(A-5) The Illinois Department may deny, suspend, or terminate the eligibility of any person, firm, corporation, association, agency, institution, or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor, if, after reasonable notice and opportunity for a hearing, the Illinois Department finds that the vendor; a person with management responsibility for a vendor; an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor; an owner of a sole proprietorship that is a vendor; or a partner in a partnership that is a vendor has been convicted of an offense based on fraud or willful misrepresentation related to any of the following:

(1) The medical assistance program under Article V of this Code.

(2) A medical assistance or health care program in

another state.

(3) The Medicare program under Title XVIII of the Social Security Act.

(4) The provision of health care services.

(5) A violation of this Code, as provided in Article VIIIA, or another state or federal medical assistance program or health care program.

(A-10) The Illinois Department may deny, suspend, or terminate the eligibility of any person, firm, corporation, association, agency, institution, or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor, if, after reasonable notice and opportunity for a hearing, the Illinois Department finds that (i) the vendor, (ii) a person with management responsibility for a vendor, (iii) an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, (iv) an owner of a sole proprietorship that is a vendor, or (v) a partner in a partnership that is a vendor has been convicted of an offense related to any of the following:

(1) Murder.

(2) A Class X felony under the Criminal Code of 1961 or the Criminal Code of 2012.

(3) Sexual misconduct that may subject recipients to

an undue risk of harm.

(4) A criminal offense that may subject recipients to an undue risk of harm.

(5) A crime of fraud or dishonesty.

(6) A crime involving a controlled substance.

(7) A misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct related to a health care program.

(A-15) The Illinois Department may deny the eligibility of any person, firm, corporation, association, agency, institution, or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V if, after reasonable notice and opportunity for a hearing, the Illinois Department finds:

(1) The applicant or any person with management responsibility for the applicant; an officer or member of the board of directors of an applicant; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant; an owner of a sole proprietorship applicant; a partner in a partnership applicant; or a technical or other advisor to an applicant has a debt owed to the Illinois Department, and no payment arrangements acceptable to the Illinois Department have been made by the applicant.

(2) The applicant or any person with management

responsibility for the applicant; an officer or member of the board of directors of an applicant; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant; an owner of a sole proprietorship applicant; a partner in a partnership vendor applicant; or a technical or other advisor to an applicant was (i) a person with management responsibility, (ii) an officer or member of the board of directors of an applicant, (iii) an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, (iv) an owner of a sole proprietorship, (v) a partner in a partnership vendor, (vi) a technical or other advisor to a vendor, during a period of time where the conduct of that vendor resulted in a debt owed to the Illinois Department, and no payment arrangements acceptable to the Illinois Department have been made by that vendor.

(3) There is a credible allegation of the use, transfer, or lease of assets of any kind to an applicant from a current or prior vendor who has a debt owed to the Illinois Department, no payment arrangements acceptable to the Illinois Department have been made by that vendor or the vendor's alternate payee, and the applicant knows or should have known of such debt.

(4) There is a credible allegation of a transfer of

management responsibilities, or direct or indirect ownership, to an applicant from a current or prior vendor who has a debt owed to the Illinois Department, and no payment arrangements acceptable to the Illinois Department have been made by that vendor or the vendor's alternate payee, and the applicant knows or should have known of such debt.

(5) There is a credible allegation of the use, transfer, or lease of assets of any kind to an applicant who is a spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, relative by marriage, nephew, cousin, or relative of a current or prior vendor who has a debt owed to the Illinois Department and no payment arrangements acceptable to the Illinois Department have been made.

(6) There is a credible allegation that the applicant's previous affiliations with a provider of medical services that has an uncollected debt, a provider that has been or is subject to a payment suspension under a federal health care program, or a provider that has been previously excluded from participation in the medical assistance program, poses a risk of fraud, waste, or abuse to the Illinois Department.

As used in this subsection, "credible allegation" is defined to include an allegation from any source, including, but not limited to, fraud hotline complaints, claims data

mining, patterns identified through provider audits, civil actions filed under the Illinois False Claims Act, and law enforcement investigations. An allegation is considered to be credible when it has indicia of reliability.

(B) The Illinois Department shall deny, suspend or terminate the eligibility of any person, firm, corporation, association, agency, institution or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor:

(1) immediately, if such vendor is not properly licensed, certified, or authorized;

(2) within 30 days of the date when such vendor's professional license, certification or other authorization has been refused renewal, restricted, revoked, suspended, or otherwise terminated; or

(3) if such vendor has been convicted of a violation of this Code, as provided in Article VIIIA.

(C) Upon termination, suspension, or exclusion of a vendor of goods or services from participation in the medical assistance program authorized by this Article, a person with management responsibility for such vendor during the time of any conduct which served as the basis for that vendor's termination, suspension, or exclusion is barred from participation in the medical assistance program.

Upon termination, suspension, or exclusion of a corporate vendor, the officers and persons owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in the vendor during the time of any conduct which served as the basis for that vendor's termination, suspension, or exclusion are barred from participation in the medical assistance program. A person who owns, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a terminated, suspended, or excluded vendor may not transfer his or her ownership interest in that vendor to his or her spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

Upon termination, suspension, or exclusion of a sole proprietorship or partnership, the owner or partners during the time of any conduct which served as the basis for that vendor's termination, suspension, or exclusion are barred from participation in the medical assistance program. The owner of a terminated, suspended, or excluded vendor that is a sole proprietorship, and a partner in a terminated, suspended, or excluded vendor that is a partnership, may not transfer his or her ownership or partnership interest in that vendor to his or her spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

A person who owns, directly or indirectly, 5% or more of

the shares of stock or other evidences of ownership in a corporate or limited liability company vendor who owes a debt to the Department, if that vendor has not made payment arrangements acceptable to the Department, shall not transfer his or her ownership interest in that vendor, or vendor assets of any kind, to his or her spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

Rules adopted by the Illinois Department to implement these provisions shall specifically include a definition of the term "management responsibility" as used in this Section. Such definition shall include, but not be limited to, typical job titles, and duties and descriptions which will be considered as within the definition of individuals with management responsibility for a provider.

A vendor or a prior vendor who has been terminated, excluded, or suspended from the medical assistance program, or from another state or federal medical assistance or health care program, and any individual currently or previously barred from the medical assistance program, or from another state or federal medical assistance or health care program, as a result of being an officer or a person owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor during the time of any conduct which served as the basis for that vendor's termination, suspension, or

exclusion, may be required to post a surety bond as part of a condition of enrollment or participation in the medical assistance program. The Illinois Department shall establish, by rule, the criteria and requirements for determining when a surety bond must be posted and the value of the bond.

A vendor or a prior vendor who has a debt owed to the Illinois Department and any individual currently or previously barred from the medical assistance program, or from another state or federal medical assistance or health care program, as a result of being an officer or a person owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in that corporate or limited liability company vendor during the time of any conduct which served as the basis for the debt, may be required to post a surety bond as part of a condition of enrollment or participation in the medical assistance program. The Illinois Department shall establish, by rule, the criteria and requirements for determining when a surety bond must be posted and the value of the bond.

(D) If a vendor has been suspended from the medical assistance program under Article V of the Code, the Director may require that such vendor correct any deficiencies which served as the basis for the suspension. The Director shall specify in the suspension order a specific period of time, which shall not exceed one year from the date of the order, during which a suspended vendor shall not be eligible to

participate. At the conclusion of the period of suspension the Director shall reinstate such vendor, unless he finds that such vendor has not corrected deficiencies upon which the suspension was based.

If a vendor has been terminated, suspended, or excluded from the medical assistance program under Article V, such vendor shall be barred from participation for at least one year, except that if a vendor has been terminated, suspended, or excluded based on a conviction of a violation of Article VIIIA or a conviction of a felony based on fraud or a willful misrepresentation related to (i) the medical assistance program under Article V, (ii) a federal or another state's medical assistance or health care program, or (iii) the provision of health care services, then the vendor shall be barred from participation for 5 years or for the length of the vendor's sentence for that conviction, whichever is longer. At the end of one year a vendor who has been terminated, suspended, or excluded may apply for reinstatement to the program. Upon proper application to be reinstated such vendor may be deemed eligible by the Director providing that such vendor meets the requirements for eligibility under this Code. If such vendor is deemed not eligible for reinstatement, he shall be barred from again applying for reinstatement for one year from the date his application for reinstatement is denied.

A vendor whose termination, suspension, or exclusion from

participation in the Illinois medical assistance program under Article V was based solely on an action by a governmental entity other than the Illinois Department may, upon reinstatement by that governmental entity or upon reversal of the termination, suspension, or exclusion, apply for rescission of the termination, suspension, or exclusion from participation in the Illinois medical assistance program. Upon proper application for rescission, the vendor may be deemed eligible by the Director if the vendor meets the requirements for eligibility under this Code.

If a vendor has been terminated, suspended, or excluded and reinstated to the medical assistance program under Article V and the vendor is terminated, suspended, or excluded a second or subsequent time from the medical assistance program, the vendor shall be barred from participation for at least 2 years, except that if a vendor has been terminated, suspended, or excluded a second time based on a conviction of a violation of Article VIIIA or a conviction of a felony based on fraud or a willful misrepresentation related to (i) the medical assistance program under Article V, (ii) a federal or another state's medical assistance or health care program, or (iii) the provision of health care services, then the vendor shall be barred from participation for life. At the end of 2 years, a vendor who has been terminated, suspended, or excluded may apply for reinstatement to the program. Upon application to be reinstated, the vendor may be deemed eligible if the vendor

meets the requirements for eligibility under this Code. If the vendor is deemed not eligible for reinstatement, the vendor shall be barred from again applying for reinstatement for 2 years from the date the vendor's application for reinstatement is denied.

(E) The Illinois Department may recover money improperly or erroneously paid, or overpayments, either by setoff, crediting against future billings or by requiring direct repayment to the Illinois Department. The Illinois Department may suspend or deny payment, in whole or in part, if such payment would be improper or erroneous or would otherwise result in overpayment.

(1) Payments may be suspended, denied, or recovered from a vendor or alternate payee: (i) for services rendered in violation of the Illinois Department's provider notices, statutes, rules, and regulations; (ii) for services rendered in violation of the terms and conditions prescribed by the Illinois Department in its vendor agreement; (iii) for any vendor who fails to grant the Office of Inspector General timely access to full and complete records, including, but not limited to, records relating to recipients under the medical assistance program for the most recent 6 years, in accordance with Section 140.28 of Title 89 of the Illinois Administrative Code, and other information for the purpose of audits, investigations, or other program integrity functions,

after reasonable written request by the Inspector General; this subsection (E) does not require vendors to make available the medical records of patients for whom services are not reimbursed under this Code or to provide access to medical records more than 6 years old; (iv) when the vendor has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the medical assistance program; or (v) when the vendor previously rendered services while terminated, suspended, or excluded from participation in the medical assistance program or while terminated or excluded from participation in another state or federal medical assistance or health care program.

(2) Notwithstanding any other provision of law, if a vendor has the same taxpayer identification number (assigned under Section 6109 of the Internal Revenue Code of 1986) as is assigned to a vendor with past-due financial obligations to the Illinois Department, the Illinois Department may make any necessary adjustments to payments to that vendor in order to satisfy any past-due obligations, regardless of whether the vendor is assigned a different billing number under the medical assistance program.

(E-5) Civil monetary penalties.

(1) As used in this subsection (E-5):

(a) "Knowingly" means that a person, with respect to information: (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

(b) "Overpayment" means any funds that a person receives or retains from the medical assistance program to which the person, after applicable reconciliation, is not entitled under this Code.

(c) "Remuneration" means the offer or transfer of items or services for free or for other than fair market value by a person; however, remuneration does not include items or services of a nominal value of no more than $10 per item or service, or $50 in the aggregate on an annual basis, or any other offer or transfer of items or services as determined by the Department.

(d) "Should know" means that a person, with respect to information: (i) acts in deliberate ignorance of the truth or falsity of the information; or (ii) acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

(2) Any person (including a vendor, provider,

organization, agency, or other entity, or an alternate payee thereof, but excluding a recipient) who:

(a) knowingly presents or causes to be presented to an officer, employee, or agent of the State, a claim that the Department determines:

(i) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided;

(ii) is for a medical or other item or service and the person knows or should know that the claim is false or fraudulent;

(iii) is presented for a vendor physician's service, or an item or service incident to a vendor physician's service, by a person who knows or should know that the individual who furnished, or supervised the furnishing of, the service:

(AA) was not licensed as a physician;

(BB) was licensed as a physician but such license had been obtained through a

misrepresentation of material fact (including cheating on an examination required for licensing); or

(CC) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board, when the individual was not so certified;

(iv) is for a medical or other item or service furnished during a period in which the person was excluded from the medical assistance program or a federal or state health care program under which the claim was made pursuant to applicable law; or

(v) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

(b) knowingly presents or causes to be presented to any person a request for payment which is in violation of the conditions for receipt of vendor payments under the medical assistance program under Section 11-13 of this Code;

(c) knowingly gives or causes to be given to any person, with respect to medical assistance program coverage of inpatient hospital services, information that he or she knows or should know is false or misleading, and that could reasonably be expected to

influence the decision when to discharge such person or other individual from the hospital;

(d) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in the medical assistance program or a federal or state health care program and who, at the time of a violation of this subsection (E-5):

(i) retains a direct or indirect ownership or control interest in an entity that is participating in the medical assistance program or a federal or state health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(ii) is an officer or managing employee of such an entity;

(e) offers or transfers remuneration to any individual eligible for benefits under the medical assistance program that such person knows or should know is likely to influence such individual to order or receive from a particular vendor, provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under the medical assistance program;

(f) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from

participation in the medical assistance program or a federal or state health care program, for the provision of items or services for which payment may be made under such a program;

(g) commits an act described in subsection (b) or (c) of Section 8A-3;

(h) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under the medical assistance program;

(i) fails to grant timely access, upon reasonable request (as defined by the Department by rule), to the Inspector General, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department;

(j) orders or prescribes a medical or other item or service during a period in which the person was excluded from the medical assistance program or a federal or state health care program, in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

(k) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a vendor or provider of

services or a supplier under the medical assistance program;

(l) knows of an overpayment and does not report and return the overpayment to the Department in accordance with paragraph (6);

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each item or service (or, in cases under subparagraph (c), $15,000 for each individual with respect to whom false or misleading information was given; in cases under subparagraph (d), $10,000 for each day the prohibited relationship occurs; in cases under subparagraph (g), $50,000 for each such act; in cases under subparagraph (h), $50,000 for each false record or statement; in cases under subparagraph (i), $15,000 for each day of the failure described in such subparagraph; or in cases under subparagraph (k), $50,000 for each false statement, omission, or misrepresentation of a material fact). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the State because of such claim (or, in cases under subparagraph (g), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for

a lawful purpose; or in cases under subparagraph (k), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application, bid, or contract containing the false statement, omission, or misrepresentation of a material fact).

(3) In addition, the Director or his or her designee may make a determination in the same proceeding to exclude, terminate, suspend, or bar the person from participation in the medical assistance program.

(4) The Illinois Department may seek the civil monetary penalties and exclusion, termination, suspension, or barment identified in this subsection (E-5). Prior to the imposition of any penalties or sanctions, the affected person shall be afforded an opportunity for a hearing after reasonable notice. The Department shall establish hearing procedures by rule.

(5) Any final order, decision, or other determination made, issued, or executed by the Director under the provisions of this subsection (E-5), whereby a person is aggrieved, shall be subject to review in accordance with the provisions of the Administrative Review Law, and the rules adopted pursuant thereto, which shall apply to and govern all proceedings for the judicial review of final administrative decisions of the Director.

(6)(a) If a person has received an overpayment, the

person shall:

(i) report and return the overpayment to the Department at the correct address; and

(ii) notify the Department in writing of the reason for the overpayment.

(b) An overpayment must be reported and returned under subparagraph (a) by the later of:

(i) the date which is 60 days after the date on which the overpayment was identified; or

(ii) the date any corresponding cost report is due, if applicable.

(E-10) A vendor who disputes an overpayment identified as part of a Department audit shall utilize the Department's self-referral disclosure protocol as set forth under this Code to identify, investigate, and return to the Department any undisputed audit overpayment amount. Unless the disputed overpayment amount is subject to a fraud payment suspension, or involves a termination sanction, the Department shall defer the recovery of the disputed overpayment amount up to one year after the date of the Department's final audit determination, or earlier, or as required by State or federal law. If the administrative hearing extends beyond one year, and such delay was not caused by the request of the vendor, then the Department shall not recover the disputed overpayment amount until the date of the final administrative decision. If a final administrative decision establishes that the disputed

overpayment amount is owed to the Department, then the amount shall be immediately due to the Department. The Department shall be entitled to recover interest from the vendor on the overpayment amount from the date of the overpayment through the date the vendor returns the overpayment to the Department at a rate not to exceed the Wall Street Journal Prime Rate, as published from time to time, but not to exceed 5%. Any interest billed by the Department shall be due immediately upon receipt of the Department's billing statement.

(F) The Illinois Department may withhold payments to any vendor or alternate payee prior to or during the pendency of any audit or proceeding under this Section, and through the pendency of any administrative appeal or administrative review by any court proceeding. The Illinois Department shall state by rule with as much specificity as practicable the conditions under which payments will not be withheld under this Section. Payments may be denied for bills submitted with service dates occurring during the pendency of a proceeding, after a final decision has been rendered, or after the conclusion of any administrative appeal, where the final administrative decision is to terminate, exclude, or suspend eligibility to participate in the medical assistance program. The Illinois Department shall state by rule with as much specificity as practicable the conditions under which payments will not be denied for such bills. The Illinois Department shall state by rule a process and criteria by which a vendor or alternate

payee may request full or partial release of payments withheld under this subsection. The Department must complete a proceeding under this Section in a timely manner.

Notwithstanding recovery allowed under subsection (E) or this subsection (F), the Illinois Department may withhold payments to any vendor or alternate payee who is not properly licensed, certified, or in compliance with State or federal agency regulations. Payments may be denied for bills submitted with service dates occurring during the period of time that a vendor is not properly licensed, certified, or in compliance with State or federal regulations. Facilities licensed under the Nursing Home Care Act shall have payments denied or withheld pursuant to subsection (I) of this Section.

(F-5) The Illinois Department may temporarily withhold payments to a vendor or alternate payee if any of the following individuals have been indicted or otherwise charged under a law of the United States or this or any other state with an offense that is based on alleged fraud or willful misrepresentation on the part of the individual related to (i) the medical assistance program under Article V of this Code, (ii) a federal or another state's medical assistance or health care program, or (iii) the provision of health care services:

(1) If the vendor or alternate payee is a corporation: an officer of the corporation or an individual who owns, either directly or indirectly, 5% or more of the shares of stock or other evidence of ownership of the corporation.

(2) If the vendor is a sole proprietorship: the owner of the sole proprietorship.

(3) If the vendor or alternate payee is a partnership: a partner in the partnership.

(4) If the vendor or alternate payee is any other business entity authorized by law to transact business in this State: an officer of the entity or an individual who owns, either directly or indirectly, 5% or more of the evidences of ownership of the entity.

If the Illinois Department withholds payments to a vendor or alternate payee under this subsection, the Department shall not release those payments to the vendor or alternate payee while any criminal proceeding related to the indictment or charge is pending unless the Department determines that there is good cause to release the payments before completion of the proceeding. If the indictment or charge results in the individual's conviction, the Illinois Department shall retain all withheld payments, which shall be considered forfeited to the Department. If the indictment or charge does not result in the individual's conviction, the Illinois Department shall release to the vendor or alternate payee all withheld payments.

(F-10) If the Illinois Department establishes that the vendor or alternate payee owes a debt to the Illinois Department, and the vendor or alternate payee subsequently fails to pay or make satisfactory payment arrangements with

the Illinois Department for the debt owed, the Illinois Department may seek all remedies available under the law of this State to recover the debt, including, but not limited to, wage garnishment or the filing of claims or liens against the vendor or alternate payee.

(F-15) Enforcement of judgment.

(1) Any fine, recovery amount, other sanction, or costs imposed, or part of any fine, recovery amount, other sanction, or cost imposed, remaining unpaid after the exhaustion of or the failure to exhaust judicial review procedures under the Illinois Administrative Review Law is a debt due and owing the State and may be collected using all remedies available under the law.

(2) After expiration of the period in which judicial review under the Illinois Administrative Review Law may be sought for a final administrative decision, unless stayed by a court of competent jurisdiction, the findings, decision, and order of the Director may be enforced in the same manner as a judgment entered by a court of competent jurisdiction.

(3) In any case in which any person or entity has failed to comply with a judgment ordering or imposing any fine or other sanction, any expenses incurred by the Illinois Department to enforce the judgment, including, but not limited to, attorney's fees, court costs, and costs related to property demolition or foreclosure, after

they are fixed by a court of competent jurisdiction or the Director, shall be a debt due and owing the State and may be collected in accordance with applicable law. Prior to any expenses being fixed by a final administrative decision pursuant to this subsection (F-15), the Illinois Department shall provide notice to the individual or entity that states that the individual or entity shall appear at a hearing before the administrative hearing officer to determine whether the individual or entity has failed to comply with the judgment. The notice shall set the date for such a hearing, which shall not be less than 7 days from the date that notice is served. If notice is served by mail, the 7-day period shall begin to run on the date that the notice was deposited in the mail.

(4) Upon being recorded in the manner required by Article XII of the Code of Civil Procedure or by the Uniform Commercial Code, a lien shall be imposed on the real estate or personal estate, or both, of the individual or entity in the amount of any debt due and owing the State under this Section. The lien may be enforced in the same manner as a judgment of a court of competent jurisdiction. A lien shall attach to all property and assets of such person, firm, corporation, association, agency, institution, or other legal entity until the judgment is satisfied.

(5) The Director may set aside any judgment entered by

default and set a new hearing date upon a petition filed at any time (i) if the petitioner's failure to appear at the hearing was for good cause, or (ii) if the petitioner established that the Department did not provide proper service of process. If any judgment is set aside pursuant to this paragraph (5), the hearing officer shall have authority to enter an order extinguishing any lien which has been recorded for any debt due and owing the Illinois Department as a result of the vacated default judgment.

(G) The provisions of the Administrative Review Law, as now or hereafter amended, and the rules adopted pursuant thereto, shall apply to and govern all proceedings for the judicial review of final administrative decisions of the Illinois Department under this Section. The term "administrative decision" is defined as in Section 3-101 of the Code of Civil Procedure.

(G-5) Vendors who pose a risk of fraud, waste, abuse, or harm.

(1) Notwithstanding any other provision in this Section, the Department may terminate, suspend, or exclude vendors who pose a risk of fraud, waste, abuse, or harm from participation in the medical assistance program prior to an evidentiary hearing but after reasonable notice and opportunity to respond as established by the Department by rule.

(2) Vendors who pose a risk of fraud, waste, abuse, or

harm shall submit to a fingerprint-based criminal background check on current and future information available in the State system and current information available through the Federal Bureau of Investigation's system by submitting all necessary fees and information in the form and manner prescribed by the Illinois State Police. The following individuals shall be subject to the check:

(A) In the case of a vendor that is a corporation, every shareholder who owns, directly or indirectly, 5% or more of the outstanding shares of the corporation.

(B) In the case of a vendor that is a partnership, every partner.

(C) In the case of a vendor that is a sole proprietorship, the sole proprietor.

(D) Each officer or manager of the vendor.

Each such vendor shall be responsible for payment of the cost of the criminal background check.

(3) Vendors who pose a risk of fraud, waste, abuse, or harm may be required to post a surety bond. The Department shall establish, by rule, the criteria and requirements for determining when a surety bond must be posted and the value of the bond.

(4) The Department, or its agents, may refuse to accept requests for authorization from specific vendors who pose a risk of fraud, waste, abuse, or harm, including

prior-approval and post-approval requests, if:

(A) the Department has initiated a notice of termination, suspension, or exclusion of the vendor from participation in the medical assistance program; or

(B) the Department has issued notification of its withholding of payments pursuant to subsection (F-5) of this Section; or

(C) the Department has issued a notification of its withholding of payments due to reliable evidence of fraud or willful misrepresentation pending investigation.

(5) As used in this subsection, the following terms are defined as follows:

(A) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

(B) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and that result in an unnecessary cost to the medical assistance program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health

care. It also includes recipient practices that result in unnecessary cost to the medical assistance program. Abuse does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible vendor liability.

(C) "Waste" means the unintentional misuse of medical assistance resources, resulting in unnecessary cost to the medical assistance program. Waste does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible vendor liability.

(D) "Harm" means physical, mental, or monetary damage to recipients or to the medical assistance program.

(G-6) The Illinois Department, upon making a determination based upon information in the possession of the Illinois Department that continuation of participation in the medical assistance program by a vendor would constitute an immediate danger to the public, may immediately suspend such vendor's participation in the medical assistance program without a hearing. In instances in which the Illinois Department immediately suspends the medical assistance program participation of a vendor under this Section, a hearing upon the vendor's participation must be convened by the Illinois Department within 15 days after such suspension and completed without appreciable delay. Such hearing shall be held to

determine whether to recommend to the Director that the vendor's medical assistance program participation be denied, terminated, suspended, placed on provisional status, or reinstated. In the hearing, any evidence relevant to the vendor constituting an immediate danger to the public may be introduced against such vendor; provided, however, that the vendor, or his or her counsel, shall have the opportunity to discredit, impeach, and submit evidence rebutting such evidence.

(H) Nothing contained in this Code shall in any way limit or otherwise impair the authority or power of any State agency responsible for licensing of vendors.

(I) Based on a finding of noncompliance on the part of a nursing home with any requirement for certification under Title XVIII or XIX of the Social Security Act (42 U.S.C. Sec. 1395 et seq. or 42 U.S.C. Sec. 1396 et seq.), the Illinois Department may impose one or more of the following remedies after notice to the facility:

(1) Termination of the provider agreement.

(2) Temporary management.

(3) Denial of payment for new admissions.

(4) Civil money penalties.

(5) Closure of the facility in emergency situations or transfer of residents, or both.

(6) State monitoring.

(7) Denial of all payments when the U.S. Department of

Health and Human Services has imposed this sanction.

The Illinois Department shall by rule establish criteria governing continued payments to a nursing facility subsequent to termination of the facility's provider agreement if, in the sole discretion of the Illinois Department, circumstances affecting the health, safety, and welfare of the facility's residents require those continued payments. The Illinois Department may condition those continued payments on the appointment of temporary management, sale of the facility to new owners or operators, or other arrangements that the Illinois Department determines best serve the needs of the facility's residents.

Except in the case of a facility that has a right to a hearing on the finding of noncompliance before an agency of the federal government, a facility may request a hearing before a State agency on any finding of noncompliance within 60 days after the notice of the intent to impose a remedy. Except in the case of civil money penalties, a request for a hearing shall not delay imposition of the penalty. The choice of remedies is not appealable at a hearing. The level of noncompliance may be challenged only in the case of a civil money penalty. The Illinois Department shall provide by rule for the State agency that will conduct the evidentiary hearings.

The Illinois Department may collect interest on unpaid civil money penalties.

The Illinois Department may adopt all rules necessary to implement this subsection (I).

(J) The Illinois Department, by rule, may permit individual practitioners to designate that Department payments that may be due the practitioner be made to an alternate payee or alternate payees.

(a) Such alternate payee or alternate payees shall be required to register as an alternate payee in the Medical Assistance Program with the Illinois Department.

(b) If a practitioner designates an alternate payee, the alternate payee and practitioner shall be jointly and severally liable to the Department for payments made to the alternate payee. Pursuant to subsection (E) of this Section, any Department action to suspend or deny payment or recover money or overpayments from an alternate payee shall be subject to an administrative hearing.

(c) Registration as an alternate payee or alternate payees in the Illinois Medical Assistance Program shall be conditional. At any time, the Illinois Department may deny or cancel any alternate payee's registration in the Illinois Medical Assistance Program without cause. Any such denial or cancellation is not subject to an administrative hearing.

(d) The Illinois Department may seek a revocation of any alternate payee, and all owners, officers, and individuals with management responsibility for such

alternate payee shall be permanently prohibited from participating as an owner, an officer, or an individual with management responsibility with an alternate payee in the Illinois Medical Assistance Program, if after reasonable notice and opportunity for a hearing the Illinois Department finds that:

(1) the alternate payee is not complying with the Department's policy or rules and regulations, or with the terms and conditions prescribed by the Illinois Department in its alternate payee registration agreement; or

(2) the alternate payee has failed to keep or make available for inspection, audit, or copying, after receiving a written request from the Illinois Department, such records regarding payments claimed as an alternate payee; or

(3) the alternate payee has failed to furnish any information requested by the Illinois Department regarding payments claimed as an alternate payee; or

(4) the alternate payee has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the Illinois Medical Assistance Program; or

(5) the alternate payee, a person with management responsibility for an alternate payee, an officer or

person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate alternate payee, or a partner in a partnership which is an alternate payee:

(a) was previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of this Code; or

(b) was a person with management responsibility for a vendor previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of this Code, during the time of conduct which was the basis for that vendor's

termination, suspension, or exclusion or alternate payee's revocation; or

(c) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of this Code, during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(d) was an owner of a sole proprietorship or partner in a partnership previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind

as the program of medical assistance provided under Article V of this Code, during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion or alternate payee's revocation; or

(6) the alternate payee, a person with management responsibility for an alternate payee, an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate alternate payee, or a partner in a partnership which is an alternate payee:

(a) has engaged in conduct prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

(b) was a person with management responsibility for a vendor or alternate payee at the time that the vendor or alternate payee engaged in practices prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

(c) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a vendor or alternate payee at the time such vendor or alternate payee engaged in practices prohibited

by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

(d) was an owner of a sole proprietorship or partner in a partnership which was a vendor or alternate payee at the time such vendor or alternate payee engaged in practices prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

(7) the direct or indirect ownership of the vendor or alternate payee (including the ownership of a vendor or alternate payee that is a partner's interest in a vendor or alternate payee, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor or alternate payee) has been transferred by an individual who is terminated, suspended, or excluded or barred from participating as a vendor or is prohibited or revoked as an alternate payee to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

(K) The Illinois Department of Healthcare and Family Services may withhold payments, in whole or in part, to a provider or alternate payee where there is credible evidence,

received from State or federal law enforcement or federal oversight agencies or from the results of a preliminary Department audit, that the circumstances giving rise to the need for a withholding of payments may involve fraud or willful misrepresentation under the Illinois Medical Assistance program. The Department shall by rule define what constitutes "credible" evidence for purposes of this subsection. The Department may withhold payments without first notifying the provider or alternate payee of its intention to withhold such payments. A provider or alternate payee may request a reconsideration of payment withholding, and the Department must grant such a request. The Department shall state by rule a process and criteria by which a provider or alternate payee may request full or partial release of payments withheld under this subsection. This request may be made at any time after the Department first withholds such payments.

(a) The Illinois Department must send notice of its withholding of program payments within 5 days of taking such action. The notice must set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning its ongoing investigation. The notice must do all of the following:

(1) State that payments are being withheld in accordance with this subsection.

(2) State that the withholding is for a temporary period, as stated in paragraph (b) of this subsection, and cite the circumstances under which withholding will be terminated.

(3) Specify, when appropriate, which type or types of Medicaid claims withholding is effective.

(4) Inform the provider or alternate payee of the right to submit written evidence for reconsideration of the withholding by the Illinois Department.

(5) Inform the provider or alternate payee that a written request may be made to the Illinois Department for full or partial release of withheld payments and that such requests may be made at any time after the Department first withholds such payments.

(b) All withholding-of-payment actions under this subsection shall be temporary and shall not continue after any of the following:

(1) The Illinois Department or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the provider or alternate payee.

(2) Legal proceedings related to the provider's or alternate payee's alleged fraud, willful misrepresentation, violations of this Act, or violations of the Illinois Department's administrative rules are completed.

(3) The withholding of payments for a period of 3 years.

(c) The Illinois Department may adopt all rules necessary to implement this subsection (K).

(K-5) The Illinois Department may withhold payments, in whole or in part, to a provider or alternate payee upon initiation of an audit, quality of care review, investigation when there is a credible allegation of fraud, or the provider or alternate payee demonstrating a clear failure to cooperate with the Illinois Department such that the circumstances give rise to the need for a withholding of payments. As used in this subsection, "credible allegation" is defined to include an allegation from any source, including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through provider audits, civil actions filed under the Illinois False Claims Act, and law enforcement investigations. An allegation is considered to be credible when it has indicia of reliability. The Illinois Department may withhold payments without first notifying the provider or alternate payee of its intention to withhold such payments. A provider or alternate payee may request a hearing or a reconsideration of payment withholding, and the Illinois Department must grant such a request. The Illinois Department shall state by rule a process and criteria by which a provider or alternate payee may request a hearing or a reconsideration for the full or partial release of payments withheld under

this subsection. This request may be made at any time after the Illinois Department first withholds such payments.

(a) The Illinois Department must send notice of its withholding of program payments within 5 days of taking such action. The notice must set forth the general allegations as to the nature of the withholding action but need not disclose any specific information concerning its ongoing investigation. The notice must do all of the following:

(1) State that payments are being withheld in accordance with this subsection.

(2) State that the withholding is for a temporary period, as stated in paragraph (b) of this subsection, and cite the circumstances under which withholding will be terminated.

(3) Specify, when appropriate, which type or types of claims are withheld.

(4) Inform the provider or alternate payee of the right to request a hearing or a reconsideration of the withholding by the Illinois Department, including the ability to submit written evidence.

(5) Inform the provider or alternate payee that a written request may be made to the Illinois Department for a hearing or a reconsideration for the full or partial release of withheld payments and that such requests may be made at any time after the Illinois

Department first withholds such payments.

(b) All withholding of payment actions under this subsection shall be temporary and shall not continue after any of the following:

(1) The Illinois Department determines that there is insufficient evidence of fraud, or the provider or alternate payee demonstrates clear cooperation with the Illinois Department, as determined by the Illinois Department, such that the circumstances do not give rise to the need for withholding of payments; or

(2) The withholding of payments has lasted for a period in excess of 3 years.

(c) The Illinois Department may adopt all rules necessary to implement this subsection (K-5).

(L) The Illinois Department shall establish a protocol to enable health care providers to disclose an actual or potential violation of this Section pursuant to a self-referral disclosure protocol, referred to in this subsection as "the protocol". The protocol shall include direction for health care providers on a specific person, official, or office to whom such disclosures shall be made. The Illinois Department shall post information on the protocol on the Illinois Department's public website. The Illinois Department may adopt rules necessary to implement this subsection (L). In addition to other factors that the Illinois Department finds appropriate, the Illinois Department may

consider a health care provider's timely use or failure to use the protocol in considering the provider's failure to comply with this Code.

(M) Notwithstanding any other provision of this Code, the Illinois Department, at its discretion, may exempt an entity licensed under the Nursing Home Care Act, the ID/DD Community Care Act, or the MC/DD Act from the provisions of subsections (A-15), (B), and (C) of this Section if the licensed entity is in receivership.

(N) Enforcement of advance payment agreements. To the extent not prohibited by federal or State law, and notwithstanding any other provision of this Code, if a provider fails to comply with the terms of an advance payment agreement, the Department is authorized to collect any unpaid advance balance through one or more of the following methods:

(1) Direct withholding of Department reimbursements. The Department may withhold reimbursement or other amounts otherwise payable by the Department to the provider, including, but not limited to, fee-for-service claims payments, supplemental payments, and any other amounts the Department is obligated to pay the provider under the medical assistance program, and apply such withheld amounts as repayment of the unpaid advance.

(2) Managed care organizations remittance. If a provider participates in a managed care program administered by the Department, the Department may direct

the managed care organization to remit to the Department amounts otherwise payable by the managed care organization to the provider, and apply such remitted amounts as repayment of the unpaid advance.

(3) Interagency recoupment. The Department may recoup amounts otherwise payable by any State agency to the provider, including, but not limited to, State grants and grant appropriations, and apply such amounts as repayment of the unpaid advance.

(4) Other collection methods. The Department may pursue any other collection remedy available at law.

The Department shall adopt rules establishing procedures for collection under this subsection (N). For purposes of this subsection (N), "provider" includes, but is not limited to, a long-term care facility as defined under the Nursing Home Care Act and a hospital provider as defined under Article V-A of this Code.

(Source: P.A. 102-538, eff. 8-20-21.)

ARTICLE 260.

Section 260-5. The Illinois Administrative Procedure Act is amended by adding Section 5-45.73 as follows:

(5 ILCS 100/5-45.73 new)

Sec. 5-45.73. Emergency rulemaking; nursing home staffing

ratios. To provide for the expeditious and timely implementation of Section 3-202.05 of the Nursing Home Care Act and changes made by this amendatory Act of the 104th General Assembly to Section 3-202.05 of the Nursing Home Care Act, emergency rules implementing Section 3-202.05 of the Nursing Home Care Act and changes made by this amendatory Act of the 104th General Assembly to Section 3-202.05 of the Nursing Home Care Act may be adopted in accordance with Section 5-45 by the Department of Public Health. The adoption of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed one year after the effective date of this amendatory Act of the 104th General Assembly.

Section 260-10. The Nursing Home Care Act is amended by changing Section 3-202.05 and by adding Section 3-130 as follows:

(210 ILCS 45/3-130 new)

Sec. 3-130. Annual training for facility staff. A facility must provide its staff with annual training based on the most recurrent citations as specified by the Department. The annual training requirements will be defined by the Department annually based on the most frequent and recurrent findings or citations during surveys or complaint investigations. The

facility must provide proof or documentation of the annual training performed for the recurrent violations. Failure to provide such proof or documentation may result in administrative fines and penalties under this Act. The Department may adopt any rules necessary to implement this Section.

The provisions of this Section are declarative of existing law.

(210 ILCS 45/3-202.05)

Sec. 3-202.05. Staffing ratios effective July 1, 2010 and thereafter.

(a) For the purpose of computing staff to resident ratios, direct care staff shall include:

(1) registered nurses;

(2) licensed practical nurses;

(3) certified nurse assistants;

(4) psychiatric services rehabilitation aides;

(5) rehabilitation and therapy aides;

(6) psychiatric services rehabilitation coordinators;

(7) assistant directors of nursing;

(8) 50% of the Director of Nurses' time; and

(9) 30% of the Social Services Directors' time.

The Department shall, by rule, allow certain facilities subject to 77 Ill. Adm. Code 300.4000 and following (Subpart S) to utilize specialized clinical staff, as defined in rules,

to count towards the staffing ratios.

Within 120 days of June 14, 2012 (the effective date of Public Act 97-689), the Department shall promulgate rules specific to the staffing requirements for facilities federally defined as Institutions for Mental Disease. These rules shall recognize the unique nature of individuals with chronic mental health conditions, shall include minimum requirements for specialized clinical staff, including clinical social workers, psychiatrists, psychologists, and direct care staff set forth in paragraphs (4) through (6) and any other specialized staff which may be utilized and deemed necessary to count toward staffing ratios.

Within 120 days of June 14, 2012 (the effective date of Public Act 97-689), the Department shall promulgate rules specific to the staffing requirements for facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013. These rules shall recognize the unique nature of individuals with chronic mental health conditions, shall include minimum requirements for specialized clinical staff, including clinical social workers, psychiatrists, psychologists, and direct care staff set forth in paragraphs (4) through (6) and any other specialized staff which may be utilized and deemed necessary to count toward staffing ratios.

(a-5) The Centers for Medicare and Medicaid Services' payroll-based journal job title codes, which correspond to the staff used for the staffing ratios in subsection (a), are as

follows:

(1) Registered Nurse Director of Nursing, job title code 5.

(2) Registered Nurse with Administrative Duties, job title code 6.

(3) Registered Nurse, job title code 7.

(4) Licensed Practical/Vocational Nurse with Administrative Duties, job title code 8.

(5) Licensed Practical/Vocational Nurse, job title code 9.

(6) Certified Nurse Aide, job title code 10.

(7) Nurse Aide in Training, job title code 11.

(8) Medication Aide/Technician, job title code 12.

(9) Nurse Practitioner, job title code 13.

(10) Clinical Nurse Specialist, job title code 14.

(11) Occupational Therapist, job title code 18.

(12) Occupational Therapy Assistant, job title code 19.

(13) Occupational Therapy Aide, job title code 20.

(14) Physical Therapist, job title code 21.

(15) Physical Therapy Assistant, job title code 22.

(16) Physical Therapy Assistant, job title code 23.

(17) Respiratory Therapist, job title code 24.

(18) Respiratory Therapy Technician, job title code 25.

(19) Speech/Language Pathologist, job title code 26.

(20) Qualified Activities Professional, job title code 28.

(21) Other Activities Staff, job title code 29.

(22) Qualified Social Worker, job title code 30.

(23) Other Social Worker, job title code 31.

(24) Mental Health Service Worker, job title code 34.

For all job title codes in this subsection, 100% of the hours worked by the staff must be counted toward the staff-to-resident ratio, except job code title 5, which is limited to 50%, and job title codes 28, 30, and 31, which are limited to 30%.

(b) (Blank).

(b-5) For purposes of the minimum staffing ratios in this Section, all residents shall be classified as requiring either skilled care or intermediate care.

As used in this subsection:

"Intermediate care" means basic nursing care and other restorative services under periodic medical direction.

"Skilled care" means skilled nursing care, continuous skilled nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision.

(c) Facilities shall notify the Department within 60 days after July 29, 2010 (the effective date of Public Act 96-1372), in a form and manner prescribed by the Department, of the staffing ratios in effect on July 29, 2010 (the

effective date of Public Act 96-1372) for both intermediate and skilled care and the number of residents receiving each level of care.

(d)(1) (Blank).

(2) (Blank).

(3) (Blank).

(4) (Blank).

(5) Effective January 1, 2014, the minimum staffing ratios shall be increased to 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and personal care each day for a resident needing intermediate care.

(e) Ninety days after June 14, 2012 (the effective date of Public Act 97-689), a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. These minimum requirements shall remain in effect until an acuity based registered nurse requirement is promulgated by rule concurrent with the adoption of the Resource Utilization Group classification-based payment methodology, as provided in Section 5-5.2 of the Illinois Public Aid Code. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. Notwithstanding this subsection, no staffing requirement in statute in effect on

June 14, 2012 (the effective date of Public Act 97-689) shall be reduced on account of this subsection.

(f) The Department shall propose rules as are necessary to implement the provisions of this Section and consistent with this amendatory Act of the 104th General Assembly within 60 days after the effective date of this amendatory Act of the 104th General Assembly. ~~submit proposed rules for adoption by January 1, 2020 establishing a system for determining compliance with minimum staffing set forth in this Section and the requirements of 77 Ill. Adm. Code 300.1230 adjusted for any waivers granted under Section 3-303.1.~~ Compliance with minimum staffing as required by this Section shall be determined on a quarterly basis. The Department shall determine compliance by comparing the number of hours provided per resident per day using the Centers for Medicare and Medicaid Services' payroll-based journal and the facility's daily census, broken down by intermediate and skilled care as self-reported by the facility to the Department on a quarterly basis. As used in this subsection, "quarterly basis" means the Centers for Medicare and Medicaid Services' quarterly reporting periods for the federal fiscal year. The Department shall use the quarterly payroll-based journal and the self-reported census to calculate the number of hours provided per resident per day and compare this ratio to the minimum staffing standards required under this Section, as impacted by any waivers granted under Section 3-303.1. Discrepancies

between job titles contained in this Section and the payroll-based journal shall be addressed by rule. The manner in which the Department requests payroll-based journal information to be submitted shall align with the federal Centers for Medicare and Medicaid Services' requirements that allow providers to submit the quarterly data in an aggregate manner.

(g) Monetary penalties for non-compliance. The Department shall propose rules that are necessary to implement the provisions of this Section, consistent with the changes made by this amendatory Act of the 104th General Assembly, within 60 days after the effective date of this amendatory Act of the 104th General Assembly. ~~submit proposed rules for adoption by January 1, 2020 establishing monetary penalties for facilities not in compliance with minimum staffing standards under this Section.~~ Facilities shall be required to comply with the provisions of this subsection beginning January 1, 2025. No monetary penalty may be issued for noncompliance prior to the revised implementation date, which shall be January 1, 2025. If a facility is found to be noncompliant prior to the revised implementation date, the Department shall provide a written notice identifying the staffing deficiencies and require the facility to provide a sufficiently detailed correction plan that describes proposed and completed actions the facility will take or has taken, including hiring actions, to address the facility's failure to meet the statutory minimum staffing

levels. Monetary penalties shall be imposed ~~beginning no later than July 1, 2025,~~ based on data for the quarter beginning July 1, 2026 through September 30, 2026 ~~January 1, 2025 through March 31, 2025~~ and quarterly thereafter. Monetary penalties shall be assessed on a quarterly basis and established based on a formula that calculates on a daily basis the cost of wages and benefits for the missing staffing hours. All notices of noncompliance shall include the computations used to determine noncompliance and establishing the variance between minimum staffing ratios and the Department's computations. The penalty for the first offense shall be 125% of the cost of wages and benefits for the missing staffing hours. The penalty shall increase to 150% of the cost of wages and benefits for the missing staffing hours for the second offense and 200% the cost of wages and benefits for the missing staffing hours for the third and all subsequent offenses. The penalty shall be imposed regardless of whether the facility has committed other violations of this Act during the same period that the staffing offense occurred. The penalty may not be waived, except where there is no more than a 10% deviation from the staffing requirements, in which case the facility shall not receive a violation or penalty. The Department shall:

(1) when calculating whether there is no more than a 10% deviation from the staffing requirements, determine the deviation based only on days of the quarter where a facility failed to meet the minimum staffing requirements;

and

(2) only assess penalties against categories of payroll-based journal job titles that deviate from the staffing requirements by more than 10%. Categories include registered nurses, licensed practical nurses, and other payroll-based journal job titles, as determined by the required staffing levels in subsection (e) of this Section and as listed in subsections (a) and (a-5) of this Section. Penalties shall not be assessed against categories of payroll-based journal job titles that have no more than a 10% deviation from staffing requirements.

The Department is granted discretion to waive the violation and penalty when unforeseen circumstances have occurred that resulted in call-offs of scheduled staff. This provision shall be applied no more than 6 times per quarter. Nothing in this Section diminishes a facility's right to appeal the imposition of a monetary penalty. No facility may appeal a notice of noncompliance issued during the revised implementation period. The changes made to this subsection by this amendatory Act of the 104th General Assembly in regard to nursing home staffing fines shall apply to ~~the July 1, 2025~~ fines based on data for the quarter beginning July 1, 2026 through September 30, 2026, ~~January 1, 2025 through March 31, 2025~~ and quarterly thereafter.

(Source: P.A. 104-9, eff. 6-16-25.)

Section 260-15. The Illinois Public Aid Code is amended by changing Sections 5-5.2 and 12-4.25 as follows:

(305 ILCS 5/5-5.2)

Sec. 5-5.2. Payment.

(a) All nursing facilities that are grouped pursuant to Section 5-5.1 of this Act shall receive the same rate of payment for similar services.

(b) It shall be a matter of State policy that the Illinois Department shall utilize a uniform billing cycle throughout the State for the long-term care providers.

(c) (Blank).

(c-1) Notwithstanding any other provisions of this Code, the methodologies for reimbursement of nursing services as provided under this Article shall no longer be applicable for bills payable for nursing services rendered on or after a new reimbursement system based on the Patient Driven Payment Model (PDPM) has been fully operationalized, which shall take effect for services provided on or after the implementation of the PDPM reimbursement system begins. For the purposes of Public Act 102-1035, the implementation date of the PDPM reimbursement system and all related provisions shall be July 1, 2022 if the following conditions are met: (i) the Centers for Medicare and Medicaid Services has approved corresponding changes in the reimbursement system and bed assessment; and (ii) the Department has filed rules to implement these changes

no later than June 1, 2022. Failure of the Department to file rules to implement the changes provided in Public Act 102-1035 no later than June 1, 2022 shall result in the implementation date being delayed to October 1, 2022.

(d) The new nursing services reimbursement methodology utilizing the Patient Driven Payment Model, which shall be referred to as the PDPM reimbursement system, taking effect July 1, 2022, upon federal approval by the Centers for Medicare and Medicaid Services, shall be based on the following:

(1) The methodology shall be resident-centered, facility-specific, cost-based, and based on guidance from the Centers for Medicare and Medicaid Services.

(2) Costs shall be annually rebased and case mix index quarterly updated. The nursing services methodology will be assigned to the Medicaid enrolled residents on record as of 30 days prior to the beginning of the rate period in the Department's Medicaid Management Information System (MMIS) as present on the last day of the second quarter preceding the rate period based upon the Assessment Reference Date of the Minimum Data Set (MDS).

(3) Regional wage adjustors based on the Health Service Areas (HSA) groupings and adjusters in effect on April 30, 2012 shall be included, except no adjuster shall be lower than 1.06.

(4) PDPM nursing case mix indices in effect on March

1, 2022 shall be assigned to each resident class at no less than 0.7858 of the Centers for Medicare and Medicaid Services PDPM unadjusted case mix values, in effect on March 1, 2022.

(5) The pool of funds available for distribution by case mix and the base facility rate shall be determined using the formula contained in subsection (d-1).

(6) The Department shall establish a variable per diem staffing add-on in accordance with the most recent available federal staffing report, currently the Payroll Based Journal, for the same period of time, and if applicable adjusted for acuity using the same quarter's MDS. The Department shall rely on Payroll Based Journals provided to the Department of Public Health to make a determination of non-submission. If the Department is notified by a facility of missing or inaccurate Payroll Based Journal data or an incorrect calculation of staffing, the Department must make a correction as soon as the error is verified for the applicable quarter.

Beginning October 1, 2024, the staffing percentage used in the calculation of the per diem staffing add-on shall be its PDPM STRIVE Staffing Ratio which equals: its Reported Total Nurse Staffing Hours Per Resident Per Day as published in the most recent federal staffing report (the Provider Information File), divided by the facility's PDPM STRIVE Staffing Target. Each facility's PDPM STRIVE

Staffing Target is equal to .82 times the facility's Illinois Adjusted Facility Case-Mix Hours Per Resident Per Day. A facility's Illinois Adjusted Facility Case Mix Hours Per Resident Per Day is equal to its Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in the most recent federal Provider Information file) times 3.662 (which reflects the national resident days-weighted mean Reported Total Nurse Staffing Hours Per Resident Per Day as calculated using the January 2024 federal Provider Information Files), divided by the national resident days-weighted mean Reported Total Nurse Staffing Hours Per Resident Per Day calculated using the most recent State US Averages file.

Beginning January 1, 2025, the staffing percentage used in the calculation of the per diem staffing add-on shall be its PDPM STRIVE Staffing Ratio which equals: its Reported Total Nurse Staffing Hours Per Resident Per Day as published in the most recent federal staffing report (the Provider Information File), divided by the facility's PDPM STRIVE Staffing Target. Each facility's PDPM STRIVE Staffing Target is equal to .7122 times the facility's Illinois Adjusted Facility Case-Mix Hours Per Resident Per Day. A facility's Illinois Adjusted Facility Case Mix Hours Per Resident Per Day is equal to its Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in the most recent federal staffing report Provider

Information file) times 3.79 (which is the Reported Total Nurse Staffing Hours Per Resident Per Day for the Nation as reported the January 2024 State US Averages file), divided by the Reported Total Nurse Staffing Hours Per Resident Per Day for the Nation as reported in the most recent State US Averages file.

(6.5) Beginning July 1, 2024, the paid per diem staffing add-on shall be the paid per diem staffing add-on in effect April 1, 2024. For dates beginning October 1, 2024 and through September 30, 2025, the denominator for the staffing percentage shall be the lesser of the facility's PDPM STRIVE Staffing Target and:

(A) For the quarter beginning October 1, 2024, the sum of 20% of the facility's PDPM STRIVE Staffing Target and 80% of the facility's Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in the January 2024 federal staffing report).

(B) For the quarter beginning January 1, 2025, the sum of 40% of the facility's PDPM STRIVE Staffing Target and 60% of the facility's Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in the January 2024 federal staffing report).

(C) For the quarter beginning March 1, 2025, the sum of 60% of the facility's PDPM STRIVE Staffing Target and 40% of the facility's Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in

the January 2024 federal staffing report).

(D) For the quarter beginning July 1, 2025, the sum of 80% of the facility's PDPM STRIVE Staffing Target and 20% of the facility's Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in the January 2024 federal staffing report).

Facilities with at least 70% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $9, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem of $16.52. Facilities with at least 80% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $16.52, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $25.77. Facilities with at least 92% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $25.77, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $30.98. Facilities with at least 100% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $30.98, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $36.44. Facilities with at least 110% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $36.44, increasing by equivalent steps for each whole percentage point until the

facilities reach a per diem add-on of $38.68. Facilities with at least 125% or higher of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $38.68. No nursing facility's variable staffing per diem add-on shall be reduced by more than 5% in 2 consecutive quarters. For the quarters beginning July 1, 2022 and October 1, 2022, no facility's variable per diem staffing add-on shall be calculated at a rate lower than 85% of the staffing indicated by the STRIVE study. No facility below 70% of the staffing indicated by the STRIVE study shall receive a variable per diem staffing add-on after December 31, 2022.

Beginning January 1, 2027, a $2.25 rate increase shall be added to each STRIVE staffing per diem add-on under subparagraph (D) of this paragraph (6.5) for facilities with at least 80% of the staffing indicated by the STRIVE study.

(7) For dates of services beginning July 1, 2022, the PDPM nursing component per diem for each nursing facility shall be the product of the facility's (i) statewide PDPM nursing base per diem rate, $92.25, adjusted for the facility average PDPM case mix index calculated quarterly and (ii) the regional wage adjuster, and then add the Medicaid access adjustment as defined in (e-3) of this Section. Transition rates for services provided between July 1, 2022 and October 1, 2023 shall be the greater of

the PDPM nursing component per diem or:

(A) for the quarter beginning July 1, 2022, the RUG-IV nursing component per diem;

(B) for the quarter beginning October 1, 2022, the sum of the RUG-IV nursing component per diem multiplied by 0.80 and the PDPM nursing component per diem multiplied by 0.20;

(C) for the quarter beginning January 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.60 and the PDPM nursing component per diem multiplied by 0.40;

(D) for the quarter beginning April 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.40 and the PDPM nursing component per diem multiplied by 0.60;

(E) for the quarter beginning July 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.20 and the PDPM nursing component per diem multiplied by 0.80; or

(F) for the quarter beginning October 1, 2023 and each subsequent quarter, the transition rate shall end and a nursing facility shall be paid 100% of the PDPM nursing component per diem.

(d-1) Calculation of base year Statewide RUG-IV nursing base per diem rate.

(1) Base rate spending pool shall be:

(A) The base year resident days which are calculated by multiplying the number of Medicaid residents in each nursing home as indicated in the MDS data defined in paragraph (4) by 365.

(B) Each facility's nursing component per diem in effect on July 1, 2012 shall be multiplied by subsection (A).

(C) Thirteen million is added to the product of subparagraph (A) and subparagraph (B) to adjust for the exclusion of nursing homes defined in paragraph (5).

(2) For each nursing home with Medicaid residents as indicated by the MDS data defined in paragraph (4), weighted days adjusted for case mix and regional wage adjustment shall be calculated. For each home this calculation is the product of:

(A) Base year resident days as calculated in subparagraph (A) of paragraph (1).

(B) The nursing home's regional wage adjustor based on the Health Service Areas (HSA) groupings and adjustors in effect on April 30, 2012.

(C) Facility weighted case mix which is the number of Medicaid residents as indicated by the MDS data defined in paragraph (4) multiplied by the associated case weight for the RUG-IV 48 grouper model using standard RUG-IV procedures for index maximization.

(D) The sum of the products calculated for each nursing home in subparagraphs (A) through (C) above shall be the base year case mix, rate adjusted weighted days.

(3) The Statewide RUG-IV nursing base per diem rate:

(A) on January 1, 2014 shall be the quotient of the paragraph (1) divided by the sum calculated under subparagraph (D) of paragraph (2);

(B) on and after July 1, 2014 and until July 1, 2022, shall be the amount calculated under subparagraph (A) of this paragraph (3) plus $1.76; and

(C) beginning July 1, 2022 and thereafter, $7 shall be added to the amount calculated under subparagraph (B) of this paragraph (3) of this Section.

(4) Minimum Data Set (MDS) comprehensive assessments for Medicaid residents on the last day of the quarter used to establish the base rate.

(5) Nursing facilities designated as of July 1, 2012 by the Department as "Institutions for Mental Disease" shall be excluded from all calculations under this subsection. The data from these facilities shall not be used in the computations described in paragraphs (1) through (4) above to establish the base rate.

(e) Beginning July 1, 2014, the Department shall allocate funding in the amount up to $10,000,000 for per diem add-ons to

the RUGS methodology for dates of service on and after July 1, 2014:

(1) $0.63 for each resident who scores in I4200 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

(2) $2.67 for each resident who scores either a "1" or "2" in any items S1200A through S1200I and also scores in RUG groups PA1, PA2, BA1, or BA2.

(e-1) (Blank).

(e-2) For dates of services beginning January 1, 2014 and ending September 30, 2023, the RUG-IV nursing component per diem for a nursing home shall be the product of the statewide RUG-IV nursing base per diem rate, the facility average case mix index, and the regional wage adjustor. For dates of service beginning July 1, 2022 and ending September 30, 2023, the Medicaid access adjustment described in subsection (e-3) shall be added to the product.

(e-3) A Medicaid Access Adjustment of $4 adjusted for the facility average PDPM case mix index calculated quarterly shall be added to the statewide PDPM nursing per diem for all facilities with annual Medicaid bed days of at least 70% of all occupied bed days adjusted quarterly. For each new calendar year and for the 6-month period beginning July 1, 2022, the percentage of a facility's occupied bed days comprised of Medicaid bed days shall be determined by the Department quarterly. For dates of service beginning January 1, 2023, the Medicaid Access Adjustment shall be increased to $4.75. This

subsection shall be inoperative on and after December 31, 2029 ~~January 1, 2028~~.

(e-3.5) For dates of service beginning January 1, 2027, the Medicaid Access Adjustment shall be increased by $5.55 to $10.30 per diem for those facilities with at least 70% of the staffing indicated by the STRIVE study as described in subparagraph (D) of paragraph (6.5) of subsection (d). A facility shall be eligible for Medicaid Access Adjustment described in this subsection (e-3.5) only if the facility demonstrates compliance with the training requirements for staff outlined in Section 3-130 of the Nursing Home Care Act. This subsection (e-3.5) shall be inoperative on and after December 31, 2029.

(e-3.6) For dates of service beginning January 1, 2027, facilities located outside of Rate Areas 6, 7, and 8 that have Medicaid bed days of at least 65% of all occupied bed days adjusted quarterly shall qualify for the Medicaid Access Adjustment described in subsections (e-3) and (e-3.5). Facilities located inside Rate Areas 6, 7, and 8 shall have their threshold remain at 70% for all qualifying facilities described in subsections (e-3) and (e-3.5). This subsection (e-3.6) shall be inoperative on and after December 31, 2029.

(e-4) Subject to federal approval, on and after January 1, 2024, the Department shall increase the rate add-on at paragraph (7) subsection (a) under 89 Ill. Adm. Code 147.335 for ventilator services from $208 per day to $481 per day.

Payment is subject to the criteria and requirements under 89 Ill. Adm. Code 147.335.

(f) (Blank).

(g) Notwithstanding any other provision of this Code, on and after July 1, 2012, for facilities not designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease", rates effective May 1, 2011 shall be adjusted as follows:

(1) (Blank);

(2) (Blank);

(3) Facility rates for the capital and support components shall be reduced by 1.7%.

(h) Notwithstanding any other provision of this Code, on and after July 1, 2012, nursing facilities designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease" and "Institutions for Mental Disease" that are facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 shall have the nursing, socio-developmental, capital, and support components of their reimbursement rate effective May 1, 2011 reduced in total by 2.7%.

(i) On and after July 1, 2014, the reimbursement rates for the support component of the nursing facility rate for facilities licensed under the Nursing Home Care Act as skilled or intermediate care facilities shall be the rate in effect on June 30, 2014 increased by 8.17%.

(i-1) Subject to federal approval, on and after January 1, 2024, the reimbursement rates for the support component of the nursing facility rate for facilities licensed under the Nursing Home Care Act as skilled or intermediate care facilities shall be the rate in effect on June 30, 2023 increased by 12%.

(j) Notwithstanding any other provision of law, subject to federal approval, effective July 1, 2019, sufficient funds shall be allocated for changes to rates for facilities licensed under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities for dates of services on and after July 1, 2019: (i) to establish, through June 30, 2022 a per diem add-on to the direct care per diem rate not to exceed $70,000,000 annually in the aggregate taking into account federal matching funds for the purpose of addressing the facility's unique staffing needs, adjusted quarterly and distributed by a weighted formula based on Medicaid bed days on the last day of the second quarter preceding the quarter for which the rate is being adjusted. Beginning July 1, 2022, the annual $70,000,000 described in the preceding sentence shall be dedicated to the variable per diem add-on for staffing under paragraph (6) of subsection (d); and (ii) in an amount not to exceed $170,000,000 annually in the aggregate taking into account federal matching funds to permit the support component of the nursing facility rate to be updated as follows:

(1) 80%, or $136,000,000, of the funds shall be used to update each facility's rate in effect on June 30, 2019 using the most recent cost reports on file, which have had a limited review conducted by the Department of Healthcare and Family Services and will not hold up enacting the rate increase, with the Department of Healthcare and Family Services.

(2) After completing the calculation in paragraph (1), any facility whose rate is less than the rate in effect on June 30, 2019 shall have its rate restored to the rate in effect on June 30, 2019 from the 20% of the funds set aside.

(3) The remainder of the 20%, or $34,000,000, shall be used to increase each facility's rate by an equal percentage.

(k) During the first quarter of State Fiscal Year 2020, the Department of Healthcare of Family Services must convene a technical advisory group consisting of members of all trade associations representing Illinois skilled nursing providers to discuss changes necessary with federal implementation of Medicare's Patient-Driven Payment Model. Implementation of Medicare's Patient-Driven Payment Model shall, by September 1, 2020, end the collection of the MDS data that is necessary to maintain the current RUG-IV Medicaid payment methodology. The technical advisory group must consider a revised reimbursement methodology that takes into account transparency,

accountability, actual staffing as reported under the federally required Payroll Based Journal system, changes to the minimum wage, adequacy in coverage of the cost of care, and a quality component that rewards quality improvements.

(l) The Department shall establish per diem add-on payments to improve the quality of care delivered by facilities, including:

(1) Incentive payments determined by facility performance on specified quality measures in an initial amount of $70,000,000. Nothing in this subsection shall be construed to limit the quality of care payments in the aggregate statewide to $70,000,000, and, if quality of care has improved across nursing facilities, the Department shall adjust those add-on payments accordingly. The quality payment methodology described in this subsection must be used for at least State Fiscal Year 2023. Beginning with the quarter starting July 1, 2023, the Department may add, remove, or change quality metrics and make associated changes to the quality payment methodology as outlined in subparagraph (E). Facilities designated by the Centers for Medicare and Medicaid Services as a special focus facility or a hospital-based nursing home do not qualify for quality payments.

(A) Each quality pool must be distributed by assigning a quality weighted score for each nursing home which is calculated by multiplying the nursing

home's quality base period Medicaid days by the nursing home's star rating weight in that period.

(B) Star rating weights are assigned based on the nursing home's star rating for the LTS quality star rating. As used in this subparagraph, "LTS quality star rating" means the long-term stay quality rating for each nursing facility, as assigned by the Centers for Medicare and Medicaid Services under the Five-Star Quality Rating System. The rating is a number ranging from 0 (lowest) to 5 (highest).

(i) Zero-star or one-star rating has a weight of 0.

(ii) Two-star rating has a weight of 0.75.

(iii) Three-star rating has a weight of 1.5.

(iv) Four-star rating has a weight of 2.5.

(v) Five-star rating has a weight of 3.5.

(C) Each nursing home's quality weight score is divided by the sum of all quality weight scores for qualifying nursing homes to determine the proportion of the quality pool to be paid to the nursing home.

(D) The quality pool is no less than $70,000,000 annually or $17,500,000 per quarter. The Department shall publish on its website the estimated payments and the associated weights for each facility 45 days prior to when the initial payments for the quarter are to be paid. The Department shall assign each facility

the most recent and applicable quarter's STAR value unless the facility notifies the Department within 15 days of an issue and the facility provides reasonable evidence demonstrating its timely compliance with federal data submission requirements for the quarter of record. If such evidence cannot be provided to the Department, the STAR rating assigned to the facility shall be reduced by one from the prior quarter.

(E) The Department shall review quality metrics used for payment of the quality pool and make recommendations for any associated changes to the methodology for distributing quality pool payments in consultation with associations representing long-term care providers, consumer advocates, organizations representing workers of long-term care facilities, and payors. The Department may establish, by rule, changes to the methodology for distributing quality pool payments.

(F) The Department shall disburse quality pool payments from the Long-Term Care Provider Fund on a monthly basis in amounts proportional to the total quality pool payment determined for the quarter.

(G) The Department shall publish any changes in the methodology for distributing quality pool payments prior to the beginning of the measurement period or quality base period for any metric added to the

distribution's methodology.

(2) Payments based on CNA tenure, promotion, and CNA training for the purpose of increasing CNA compensation. It is the intent of this subsection that payments made in accordance with this paragraph be directly incorporated into increased compensation for CNAs. As used in this paragraph, "CNA" means a certified nursing assistant as that term is described in Section 3-206 of the Nursing Home Care Act, Section 3-206 of the ID/DD Community Care Act, and Section 3-206 of the MC/DD Act. The Department shall establish, by rule, payments to nursing facilities equal to Medicaid's share of the tenure wage increments specified in this paragraph for all reported CNA employee hours compensated according to a posted schedule consisting of increments at least as large as those specified in this paragraph. The increments are as follows: an additional $1.50 per hour for CNAs with at least one and less than 2 years' experience plus another $1 per hour for each additional year of experience up to a maximum of $6.50 for CNAs with at least 6 years of experience. For purposes of this paragraph, Medicaid's share shall be the ratio determined by paid Medicaid bed days divided by total bed days for the applicable time period used in the calculation. In addition, and additive to any tenure increments paid as specified in this paragraph, the Department shall establish, by rule,

payments supporting Medicaid's share of the promotion-based wage increments for CNA employee hours compensated for that promotion with at least a $1.50 hourly increase. Medicaid's share shall be established as it is for the tenure increments described in this paragraph. Qualifying promotions shall be defined by the Department in rules for an expected 10-15% subset of CNAs assigned intermediate, specialized, or added roles such as CNA trainers, CNA scheduling "captains", and CNA specialists for resident conditions like dementia or memory care or behavioral health.

(m) The Department shall work with nursing facility industry representatives to design policies and procedures to permit facilities to address the integrity of data from federal reporting sites used by the Department in setting facility rates.

(Source: P.A. 102-77, eff. 7-9-21; 102-558, eff. 8-20-21; 102-1035, eff. 5-31-22; 102-1118, eff. 1-18-23; 103-102, Article 40, Section 40-5, eff. 1-1-24; 103-102, Article 50, Section 50-5, eff. 1-1-24; 103-593, eff. 6-7-24; 103-605, eff. 7-1-24; 103-1075, eff. 3-21-25.)

(305 ILCS 5/12-4.25) (from Ch. 23, par. 12-4.25)

Sec. 12-4.25. Medical assistance program; vendor participation.

(A) The Illinois Department may deny, suspend, or

terminate the eligibility of any person, firm, corporation, association, agency, institution or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor, and may deny, suspend, or recover payments, if after reasonable notice and opportunity for a hearing the Illinois Department finds:

(a) Such vendor is not complying with the Department's policy or rules and regulations, or with the terms and conditions prescribed by the Illinois Department in its vendor agreement, which document shall be developed by the Department as a result of negotiations with each vendor category, including physicians, hospitals, long term care facilities, pharmacists, optometrists, podiatric physicians, and dentists setting forth the terms and conditions applicable to the participation of each vendor group in the program; or

(b) Such vendor has failed to keep or make available for inspection, audit or copying, after receiving a written request from the Illinois Department, such records regarding payments claimed for providing services. This section does not require vendors to make available patient records of patients for whom services are not reimbursed under this Code; or

(c) Such vendor has failed to furnish any information

requested by the Department regarding payments for providing goods or services; or

(d) Such vendor has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the medical assistance program; or

(e) Such vendor has furnished goods or services to a recipient which are (1) in excess of need, (2) harmful, or (3) of grossly inferior quality, all of such determinations to be based upon competent medical judgment and evaluations; or

(f) The vendor; a person with management responsibility for a vendor; an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor; an owner of a sole proprietorship which is a vendor; or a partner in a partnership which is a vendor, either:

(1) was previously terminated, suspended, or excluded from participation in the Illinois medical assistance program, or was terminated, suspended, or excluded from participation in another state or federal medical assistance or health care program; or

(2) was a person with management responsibility for a vendor previously terminated, suspended, or excluded from participation in the Illinois medical

assistance program, or terminated, suspended, or excluded from participation in another state or federal medical assistance or health care program during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(3) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor previously terminated, suspended, or excluded from participation in the Illinois medical assistance program, or terminated, suspended, or excluded from participation in a state or federal medical assistance or health care program during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(4) was an owner of a sole proprietorship or partner of a partnership previously terminated, suspended, or excluded from participation in the Illinois medical assistance program, or terminated, suspended, or excluded from participation in a state or federal medical assistance or health care program during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(f-1) Such vendor has a delinquent debt owed to the Illinois Department; or

(g) The vendor; a person with management responsibility for a vendor; an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor; an owner of a sole proprietorship which is a vendor; or a partner in a partnership which is a vendor, either:

(1) has engaged in practices prohibited by applicable federal or State law or regulation; or

(2) was a person with management responsibility for a vendor at the time that such vendor engaged in practices prohibited by applicable federal or State law or regulation; or

(3) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a vendor at the time such vendor engaged in practices prohibited by applicable federal or State law or regulation; or

(4) was an owner of a sole proprietorship or partner of a partnership which was a vendor at the time such vendor engaged in practices prohibited by applicable federal or State law or regulation; or

(h) The direct or indirect ownership of the vendor (including the ownership of a vendor that is a sole proprietorship, a partner's interest in a vendor that is a partnership, or ownership of 5% or more of the shares of

stock or other evidences of ownership in a corporate vendor) has been transferred by an individual who is terminated, suspended, or excluded or barred from participating as a vendor to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

(A-5) The Illinois Department may deny, suspend, or terminate the eligibility of any person, firm, corporation, association, agency, institution, or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor, if, after reasonable notice and opportunity for a hearing, the Illinois Department finds that the vendor; a person with management responsibility for a vendor; an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor; an owner of a sole proprietorship that is a vendor; or a partner in a partnership that is a vendor has been convicted of an offense based on fraud or willful misrepresentation related to any of the following:

(1) The medical assistance program under Article V of this Code.

(2) A medical assistance or health care program in another state.

(3) The Medicare program under Title XVIII of the Social Security Act.

(4) The provision of health care services.

(5) A violation of this Code, as provided in Article VIIIA, or another state or federal medical assistance program or health care program.

(A-10) The Illinois Department may deny, suspend, or terminate the eligibility of any person, firm, corporation, association, agency, institution, or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor, if, after reasonable notice and opportunity for a hearing, the Illinois Department finds that (i) the vendor, (ii) a person with management responsibility for a vendor, (iii) an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, (iv) an owner of a sole proprietorship that is a vendor, or (v) a partner in a partnership that is a vendor has been convicted of an offense related to any of the following:

(1) Murder.

(2) A Class X felony under the Criminal Code of 1961 or the Criminal Code of 2012.

(3) Sexual misconduct that may subject recipients to an undue risk of harm.

(4) A criminal offense that may subject recipients to an undue risk of harm.

(5) A crime of fraud or dishonesty.

(6) A crime involving a controlled substance.

(7) A misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct related to a health care program.

(A-15) The Illinois Department may deny the eligibility of any person, firm, corporation, association, agency, institution, or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V if, after reasonable notice and opportunity for a hearing, the Illinois Department finds:

(1) The applicant or any person with management responsibility for the applicant; an officer or member of the board of directors of an applicant; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant; an owner of a sole proprietorship applicant; a partner in a partnership applicant; or a technical or other advisor to an applicant has a debt owed to the Illinois Department, and no payment arrangements acceptable to the Illinois Department have been made by the applicant.

(2) The applicant or any person with management responsibility for the applicant; an officer or member of

the board of directors of an applicant; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant; an owner of a sole proprietorship applicant; a partner in a partnership vendor applicant; or a technical or other advisor to an applicant was (i) a person with management responsibility, (ii) an officer or member of the board of directors of an applicant, (iii) an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, (iv) an owner of a sole proprietorship, (v) a partner in a partnership vendor, (vi) a technical or other advisor to a vendor, during a period of time where the conduct of that vendor resulted in a debt owed to the Illinois Department, and no payment arrangements acceptable to the Illinois Department have been made by that vendor.

(3) There is a credible allegation of the use, transfer, or lease of assets of any kind to an applicant from a current or prior vendor who has a debt owed to the Illinois Department, no payment arrangements acceptable to the Illinois Department have been made by that vendor or the vendor's alternate payee, and the applicant knows or should have known of such debt.

(4) There is a credible allegation of a transfer of management responsibilities, or direct or indirect

ownership, to an applicant from a current or prior vendor who has a debt owed to the Illinois Department, and no payment arrangements acceptable to the Illinois Department have been made by that vendor or the vendor's alternate payee, and the applicant knows or should have known of such debt.

(5) There is a credible allegation of the use, transfer, or lease of assets of any kind to an applicant who is a spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, relative by marriage, nephew, cousin, or relative of a current or prior vendor who has a debt owed to the Illinois Department and no payment arrangements acceptable to the Illinois Department have been made.

(6) There is a credible allegation that the applicant's previous affiliations with a provider of medical services that has an uncollected debt, a provider that has been or is subject to a payment suspension under a federal health care program, or a provider that has been previously excluded from participation in the medical assistance program, poses a risk of fraud, waste, or abuse to the Illinois Department.

As used in this subsection, "credible allegation" is defined to include an allegation from any source, including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through provider audits, civil

actions filed under the Illinois False Claims Act, and law enforcement investigations. An allegation is considered to be credible when it has indicia of reliability.

(B) The Illinois Department shall deny, suspend or terminate the eligibility of any person, firm, corporation, association, agency, institution or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor:

(1) immediately, if such vendor is not properly licensed, certified, or authorized;

(2) within 30 days of the date when such vendor's professional license, certification or other authorization has been refused renewal, restricted, revoked, suspended, or otherwise terminated; or

(3) if such vendor has been convicted of a violation of this Code, as provided in Article VIIIA.

(C) Upon termination, suspension, or exclusion of a vendor of goods or services from participation in the medical assistance program authorized by this Article, a person with management responsibility for such vendor during the time of any conduct which served as the basis for that vendor's termination, suspension, or exclusion is barred from participation in the medical assistance program.

Upon termination, suspension, or exclusion of a corporate

vendor, the officers and persons owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in the vendor during the time of any conduct which served as the basis for that vendor's termination, suspension, or exclusion are barred from participation in the medical assistance program. A person who owns, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a terminated, suspended, or excluded vendor may not transfer his or her ownership interest in that vendor to his or her spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

Upon termination, suspension, or exclusion of a sole proprietorship or partnership, the owner or partners during the time of any conduct which served as the basis for that vendor's termination, suspension, or exclusion are barred from participation in the medical assistance program. The owner of a terminated, suspended, or excluded vendor that is a sole proprietorship, and a partner in a terminated, suspended, or excluded vendor that is a partnership, may not transfer his or her ownership or partnership interest in that vendor to his or her spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

A person who owns, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a

corporate or limited liability company vendor who owes a debt to the Department, if that vendor has not made payment arrangements acceptable to the Department, shall not transfer his or her ownership interest in that vendor, or vendor assets of any kind, to his or her spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

Rules adopted by the Illinois Department to implement these provisions shall specifically include a definition of the term "management responsibility" as used in this Section. Such definition shall include, but not be limited to, typical job titles, and duties and descriptions which will be considered as within the definition of individuals with management responsibility for a provider.

A vendor or a prior vendor who has been terminated, excluded, or suspended from the medical assistance program, or from another state or federal medical assistance or health care program, and any individual currently or previously barred from the medical assistance program, or from another state or federal medical assistance or health care program, as a result of being an officer or a person owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor during the time of any conduct which served as the basis for that vendor's termination, suspension, or exclusion, may be required to post a surety bond as part of a

condition of enrollment or participation in the medical assistance program. The Illinois Department shall establish, by rule, the criteria and requirements for determining when a surety bond must be posted and the value of the bond.

A vendor or a prior vendor who has a debt owed to the Illinois Department and any individual currently or previously barred from the medical assistance program, or from another state or federal medical assistance or health care program, as a result of being an officer or a person owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in that corporate or limited liability company vendor during the time of any conduct which served as the basis for the debt, may be required to post a surety bond as part of a condition of enrollment or participation in the medical assistance program. The Illinois Department shall establish, by rule, the criteria and requirements for determining when a surety bond must be posted and the value of the bond.

(D) If a vendor has been suspended from the medical assistance program under Article V of the Code, the Director may require that such vendor correct any deficiencies which served as the basis for the suspension. The Director shall specify in the suspension order a specific period of time, which shall not exceed one year from the date of the order, during which a suspended vendor shall not be eligible to participate. At the conclusion of the period of suspension the

Director shall reinstate such vendor, unless he finds that such vendor has not corrected deficiencies upon which the suspension was based.

If a vendor has been terminated, suspended, or excluded from the medical assistance program under Article V, such vendor shall be barred from participation for at least one year, except that if a vendor has been terminated, suspended, or excluded based on a conviction of a violation of Article VIIIA or a conviction of a felony based on fraud or a willful misrepresentation related to (i) the medical assistance program under Article V, (ii) a federal or another state's medical assistance or health care program, or (iii) the provision of health care services, then the vendor shall be barred from participation for 5 years or for the length of the vendor's sentence for that conviction, whichever is longer. At the end of one year a vendor who has been terminated, suspended, or excluded may apply for reinstatement to the program. Upon proper application to be reinstated such vendor may be deemed eligible by the Director providing that such vendor meets the requirements for eligibility under this Code. If such vendor is deemed not eligible for reinstatement, he shall be barred from again applying for reinstatement for one year from the date his application for reinstatement is denied.

A vendor whose termination, suspension, or exclusion from participation in the Illinois medical assistance program under

Article V was based solely on an action by a governmental entity other than the Illinois Department may, upon reinstatement by that governmental entity or upon reversal of the termination, suspension, or exclusion, apply for rescission of the termination, suspension, or exclusion from participation in the Illinois medical assistance program. Upon proper application for rescission, the vendor may be deemed eligible by the Director if the vendor meets the requirements for eligibility under this Code.

If a vendor has been terminated, suspended, or excluded and reinstated to the medical assistance program under Article V and the vendor is terminated, suspended, or excluded a second or subsequent time from the medical assistance program, the vendor shall be barred from participation for at least 2 years, except that if a vendor has been terminated, suspended, or excluded a second time based on a conviction of a violation of Article VIIIA or a conviction of a felony based on fraud or a willful misrepresentation related to (i) the medical assistance program under Article V, (ii) a federal or another state's medical assistance or health care program, or (iii) the provision of health care services, then the vendor shall be barred from participation for life. At the end of 2 years, a vendor who has been terminated, suspended, or excluded may apply for reinstatement to the program. Upon application to be reinstated, the vendor may be deemed eligible if the vendor meets the requirements for eligibility under this Code. If the

vendor is deemed not eligible for reinstatement, the vendor shall be barred from again applying for reinstatement for 2 years from the date the vendor's application for reinstatement is denied.

(E) The Illinois Department may recover money improperly or erroneously paid, or overpayments, either by setoff, crediting against future billings or by requiring direct repayment to the Illinois Department. The Illinois Department may suspend or deny payment, in whole or in part, if such payment would be improper or erroneous or would otherwise result in overpayment.

(1) Payments may be suspended, denied, or recovered from a vendor or alternate payee: (i) for services rendered in violation of the Illinois Department's provider notices, statutes, rules, and regulations; (ii) for services rendered in violation of the terms and conditions prescribed by the Illinois Department in its vendor agreement; (iii) for any vendor who fails to grant the Office of Inspector General timely access to full and complete records, including, but not limited to, records relating to recipients under the medical assistance program for the most recent 6 years, in accordance with Section 140.28 of Title 89 of the Illinois Administrative Code, and other information for the purpose of audits, investigations, or other program integrity functions, after reasonable written request by the Inspector General;

this subsection (E) does not require vendors to make available the medical records of patients for whom services are not reimbursed under this Code or to provide access to medical records more than 6 years old; (iv) when the vendor has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the medical assistance program; or (v) when the vendor previously rendered services while terminated, suspended, or excluded from participation in the medical assistance program or while terminated or excluded from participation in another state or federal medical assistance or health care program.

(2) Notwithstanding any other provision of law, if a vendor has the same taxpayer identification number (assigned under Section 6109 of the Internal Revenue Code of 1986) as is assigned to a vendor with past-due financial obligations to the Illinois Department, the Illinois Department may make any necessary adjustments to payments to that vendor in order to satisfy any past-due obligations, regardless of whether the vendor is assigned a different billing number under the medical assistance program.

(E-5) Civil monetary penalties.

(1) As used in this subsection (E-5):

(a) "Knowingly" means that a person, with respect

to information: (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

(b) "Overpayment" means any funds that a person receives or retains from the medical assistance program to which the person, after applicable reconciliation, is not entitled under this Code.

(c) "Remuneration" means the offer or transfer of items or services for free or for other than fair market value by a person; however, remuneration does not include items or services of a nominal value of no more than $10 per item or service, or $50 in the aggregate on an annual basis, or any other offer or transfer of items or services as determined by the Department.

(d) "Should know" means that a person, with respect to information: (i) acts in deliberate ignorance of the truth or falsity of the information; or (ii) acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

(2) Any person (including a vendor, provider, organization, agency, or other entity, or an alternate

payee thereof, but excluding a recipient) who:

(a) knowingly presents or causes to be presented to an officer, employee, or agent of the State, a claim that the Department determines:

(i) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided;

(ii) is for a medical or other item or service and the person knows or should know that the claim is false or fraudulent;

(iii) is presented for a vendor physician's service, or an item or service incident to a vendor physician's service, by a person who knows or should know that the individual who furnished, or supervised the furnishing of, the service:

(AA) was not licensed as a physician;

(BB) was licensed as a physician but such license had been obtained through a misrepresentation of material fact (including

cheating on an examination required for licensing); or

(CC) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board, when the individual was not so certified;

(iv) is for a medical or other item or service furnished during a period in which the person was excluded from the medical assistance program or a federal or state health care program under which the claim was made pursuant to applicable law; or

(v) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

(b) knowingly presents or causes to be presented to any person a request for payment which is in violation of the conditions for receipt of vendor payments under the medical assistance program under Section 11-13 of this Code;

(c) knowingly gives or causes to be given to any person, with respect to medical assistance program coverage of inpatient hospital services, information that he or she knows or should know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person

or other individual from the hospital;

(d) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in the medical assistance program or a federal or state health care program and who, at the time of a violation of this subsection (E-5):

(i) retains a direct or indirect ownership or control interest in an entity that is participating in the medical assistance program or a federal or state health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(ii) is an officer or managing employee of such an entity;

(e) offers or transfers remuneration to any individual eligible for benefits under the medical assistance program that such person knows or should know is likely to influence such individual to order or receive from a particular vendor, provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under the medical assistance program;

(f) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in the medical assistance program or a

federal or state health care program, for the provision of items or services for which payment may be made under such a program;

(g) commits an act described in subsection (b) or (c) of Section 8A-3;

(h) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under the medical assistance program;

(i) fails to grant timely access, upon reasonable request (as defined by the Department by rule), to the Inspector General, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department;

(j) orders or prescribes a medical or other item or service during a period in which the person was excluded from the medical assistance program or a federal or state health care program, in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

(k) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a vendor or provider of services or a supplier under the medical assistance

program;

(l) knows of an overpayment and does not report and return the overpayment to the Department in accordance with paragraph (6);

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each item or service (or, in cases under subparagraph (c), $15,000 for each individual with respect to whom false or misleading information was given; in cases under subparagraph (d), $10,000 for each day the prohibited relationship occurs; in cases under subparagraph (g), $50,000 for each such act; in cases under subparagraph (h), $50,000 for each false record or statement; in cases under subparagraph (i), $15,000 for each day of the failure described in such subparagraph; or in cases under subparagraph (k), $50,000 for each false statement, omission, or misrepresentation of a material fact). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the State because of such claim (or, in cases under subparagraph (g), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose; or in cases under subparagraph (k), an

assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application, bid, or contract containing the false statement, omission, or misrepresentation of a material fact).

(3) In addition, the Director or his or her designee may make a determination in the same proceeding to exclude, terminate, suspend, or bar the person from participation in the medical assistance program.

(4) The Illinois Department may seek the civil monetary penalties and exclusion, termination, suspension, or barment identified in this subsection (E-5). Prior to the imposition of any penalties or sanctions, the affected person shall be afforded an opportunity for a hearing after reasonable notice. The Department shall establish hearing procedures by rule.

(5) Any final order, decision, or other determination made, issued, or executed by the Director under the provisions of this subsection (E-5), whereby a person is aggrieved, shall be subject to review in accordance with the provisions of the Administrative Review Law, and the rules adopted pursuant thereto, which shall apply to and govern all proceedings for the judicial review of final administrative decisions of the Director.

(6)(a) If a person has received an overpayment, the person shall:

(i) report and return the overpayment to the Department at the correct address; and

(ii) notify the Department in writing of the reason for the overpayment.

(b) An overpayment must be reported and returned under subparagraph (a) by the later of:

(i) the date which is 60 days after the date on which the overpayment was identified; or

(ii) the date any corresponding cost report is due, if applicable.

(E-10) A vendor who disputes an overpayment identified as part of a Department audit shall utilize the Department's self-referral disclosure protocol as set forth under this Code to identify, investigate, and return to the Department any undisputed audit overpayment amount. Unless the disputed overpayment amount is subject to a fraud payment suspension, or involves a termination sanction, the Department shall defer the recovery of the disputed overpayment amount up to one year after the date of the Department's final audit determination, or earlier, or as required by State or federal law. If the administrative hearing extends beyond one year, and such delay was not caused by the request of the vendor, then the Department shall not recover the disputed overpayment amount until the date of the final administrative decision. If a final administrative decision establishes that the disputed overpayment amount is owed to the Department, then the amount

shall be immediately due to the Department. The Department shall be entitled to recover interest from the vendor on the overpayment amount from the date of the overpayment through the date the vendor returns the overpayment to the Department at a rate not to exceed the Wall Street Journal Prime Rate, as published from time to time, but not to exceed 5%. Any interest billed by the Department shall be due immediately upon receipt of the Department's billing statement.

(F) The Illinois Department may withhold payments to any vendor or alternate payee prior to or during the pendency of any audit or proceeding under this Section, and through the pendency of any administrative appeal or administrative review by any court proceeding. The Illinois Department shall state by rule with as much specificity as practicable the conditions under which payments will not be withheld under this Section. Payments may be denied for bills submitted with service dates occurring during the pendency of a proceeding, after a final decision has been rendered, or after the conclusion of any administrative appeal, where the final administrative decision is to terminate, exclude, or suspend eligibility to participate in the medical assistance program. The Illinois Department shall state by rule with as much specificity as practicable the conditions under which payments will not be denied for such bills. The Illinois Department shall state by rule a process and criteria by which a vendor or alternate payee may request full or partial release of payments withheld

under this subsection. The Department must complete a proceeding under this Section in a timely manner.

Notwithstanding recovery allowed under subsection (E) or this subsection (F), the Illinois Department may withhold payments to any vendor or alternate payee who is not properly licensed, certified, or in compliance with State or federal agency regulations. Payments may be denied for bills submitted with service dates occurring during the period of time that a vendor is not properly licensed, certified, or in compliance with State or federal regulations. Facilities licensed under the Nursing Home Care Act shall have payments denied or withheld pursuant to subsection (I) of this Section.

(F-5) The Illinois Department may temporarily withhold payments to a vendor or alternate payee if any of the following individuals have been indicted or otherwise charged under a law of the United States or this or any other state with an offense that is based on alleged fraud or willful misrepresentation on the part of the individual related to (i) the medical assistance program under Article V of this Code, (ii) a federal or another state's medical assistance or health care program, or (iii) the provision of health care services:

(1) If the vendor or alternate payee is a corporation: an officer of the corporation or an individual who owns, either directly or indirectly, 5% or more of the shares of stock or other evidence of ownership of the corporation.

(2) If the vendor is a sole proprietorship: the owner

of the sole proprietorship.

(3) If the vendor or alternate payee is a partnership: a partner in the partnership.

(4) If the vendor or alternate payee is any other business entity authorized by law to transact business in this State: an officer of the entity or an individual who owns, either directly or indirectly, 5% or more of the evidences of ownership of the entity.

If the Illinois Department withholds payments to a vendor or alternate payee under this subsection, the Department shall not release those payments to the vendor or alternate payee while any criminal proceeding related to the indictment or charge is pending unless the Department determines that there is good cause to release the payments before completion of the proceeding. If the indictment or charge results in the individual's conviction, the Illinois Department shall retain all withheld payments, which shall be considered forfeited to the Department. If the indictment or charge does not result in the individual's conviction, the Illinois Department shall release to the vendor or alternate payee all withheld payments.

(F-10) If the Illinois Department establishes that the vendor or alternate payee owes a debt to the Illinois Department, and the vendor or alternate payee subsequently fails to pay or make satisfactory payment arrangements with the Illinois Department for the debt owed, the Illinois

Department may seek all remedies available under the law of this State to recover the debt, including, but not limited to, wage garnishment or the filing of claims or liens against the vendor or alternate payee.

(F-15) Enforcement of judgment.

(1) Any fine, recovery amount, other sanction, or costs imposed, or part of any fine, recovery amount, other sanction, or cost imposed, remaining unpaid after the exhaustion of or the failure to exhaust judicial review procedures under the Illinois Administrative Review Law is a debt due and owing the State and may be collected using all remedies available under the law.

(2) After expiration of the period in which judicial review under the Illinois Administrative Review Law may be sought for a final administrative decision, unless stayed by a court of competent jurisdiction, the findings, decision, and order of the Director may be enforced in the same manner as a judgment entered by a court of competent jurisdiction.

(3) In any case in which any person or entity has failed to comply with a judgment ordering or imposing any fine or other sanction, any expenses incurred by the Illinois Department to enforce the judgment, including, but not limited to, attorney's fees, court costs, and costs related to property demolition or foreclosure, after they are fixed by a court of competent jurisdiction or the

Director, shall be a debt due and owing the State and may be collected in accordance with applicable law. Prior to any expenses being fixed by a final administrative decision pursuant to this subsection (F-15), the Illinois Department shall provide notice to the individual or entity that states that the individual or entity shall appear at a hearing before the administrative hearing officer to determine whether the individual or entity has failed to comply with the judgment. The notice shall set the date for such a hearing, which shall not be less than 7 days from the date that notice is served. If notice is served by mail, the 7-day period shall begin to run on the date that the notice was deposited in the mail.

(4) Upon being recorded in the manner required by Article XII of the Code of Civil Procedure or by the Uniform Commercial Code, a lien shall be imposed on the real estate or personal estate, or both, of the individual or entity in the amount of any debt due and owing the State under this Section. The lien may be enforced in the same manner as a judgment of a court of competent jurisdiction. A lien shall attach to all property and assets of such person, firm, corporation, association, agency, institution, or other legal entity until the judgment is satisfied.

(5) The Director may set aside any judgment entered by default and set a new hearing date upon a petition filed at

any time (i) if the petitioner's failure to appear at the hearing was for good cause, or (ii) if the petitioner established that the Department did not provide proper service of process. If any judgment is set aside pursuant to this paragraph (5), the hearing officer shall have authority to enter an order extinguishing any lien which has been recorded for any debt due and owing the Illinois Department as a result of the vacated default judgment.

(G) The provisions of the Administrative Review Law, as now or hereafter amended, and the rules adopted pursuant thereto, shall apply to and govern all proceedings for the judicial review of final administrative decisions of the Illinois Department under this Section. The term "administrative decision" is defined as in Section 3-101 of the Code of Civil Procedure.

(G-5) Vendors who pose a risk of fraud, waste, abuse, or harm.

(1) Notwithstanding any other provision in this Section, the Department may terminate, suspend, or exclude vendors who pose a risk of fraud, waste, abuse, or harm from participation in the medical assistance program prior to an evidentiary hearing but after reasonable notice and opportunity to respond as established by the Department by rule.

(2) Vendors who pose a risk of fraud, waste, abuse, or harm shall submit to a fingerprint-based criminal

background check on current and future information available in the State system and current information available through the Federal Bureau of Investigation's system by submitting all necessary fees and information in the form and manner prescribed by the Illinois State Police. The following individuals shall be subject to the check:

(A) In the case of a vendor that is a corporation, every shareholder who owns, directly or indirectly, 5% or more of the outstanding shares of the corporation.

(B) In the case of a vendor that is a partnership, every partner.

(C) In the case of a vendor that is a sole proprietorship, the sole proprietor.

(D) Each officer or manager of the vendor.

Each such vendor shall be responsible for payment of the cost of the criminal background check.

(3) Vendors who pose a risk of fraud, waste, abuse, or harm may be required to post a surety bond. The Department shall establish, by rule, the criteria and requirements for determining when a surety bond must be posted and the value of the bond.

(4) The Department, or its agents, may refuse to accept requests for authorization from specific vendors who pose a risk of fraud, waste, abuse, or harm, including prior-approval and post-approval requests, if:

(A) the Department has initiated a notice of termination, suspension, or exclusion of the vendor from participation in the medical assistance program; or

(B) the Department has issued notification of its withholding of payments pursuant to subsection (F-5) of this Section; or

(C) the Department has issued a notification of its withholding of payments due to reliable evidence of fraud or willful misrepresentation pending investigation.

(5) As used in this subsection, the following terms are defined as follows:

(A) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

(B) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and that result in an unnecessary cost to the medical assistance program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result

in unnecessary cost to the medical assistance program. Abuse does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible vendor liability.

(C) "Waste" means the unintentional misuse of medical assistance resources, resulting in unnecessary cost to the medical assistance program. Waste does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible vendor liability.

(D) "Harm" means physical, mental, or monetary damage to recipients or to the medical assistance program.

(G-6) The Illinois Department, upon making a determination based upon information in the possession of the Illinois Department that continuation of participation in the medical assistance program by a vendor would constitute an immediate danger to the public, may immediately suspend such vendor's participation in the medical assistance program without a hearing. In instances in which the Illinois Department immediately suspends the medical assistance program participation of a vendor under this Section, a hearing upon the vendor's participation must be convened by the Illinois Department within 15 days after such suspension and completed without appreciable delay. Such hearing shall be held to determine whether to recommend to the Director that the

vendor's medical assistance program participation be denied, terminated, suspended, placed on provisional status, or reinstated. In the hearing, any evidence relevant to the vendor constituting an immediate danger to the public may be introduced against such vendor; provided, however, that the vendor, or his or her counsel, shall have the opportunity to discredit, impeach, and submit evidence rebutting such evidence.

(H) Nothing contained in this Code shall in any way limit or otherwise impair the authority or power of any State agency responsible for licensing of vendors.

(I) Based on a finding of noncompliance on the part of a nursing home with any requirement for certification under Title XVIII or XIX of the Social Security Act (42 U.S.C. Sec. 1395 et seq. or 42 U.S.C. Sec. 1396 et seq.), the Illinois Department may impose one or more of the following remedies after notice to the facility:

(1) Termination of the provider agreement.

(2) Temporary management.

(3) Denial of payment for new admissions.

(4) Civil money penalties.

(5) Closure of the facility in emergency situations or transfer of residents, or both.

(6) State monitoring.

(7) Denial of all payments when the U.S. Department of Health and Human Services has imposed this sanction.

The Illinois Department shall by rule establish criteria governing continued payments to a nursing facility subsequent to termination of the facility's provider agreement if, in the sole discretion of the Illinois Department, circumstances affecting the health, safety, and welfare of the facility's residents require those continued payments. The Illinois Department may condition those continued payments on the appointment of temporary management, sale of the facility to new owners or operators, or other arrangements that the Illinois Department determines best serve the needs of the facility's residents.

Except in the case of a facility that has a right to a hearing on the finding of noncompliance before an agency of the federal government, a facility may request a hearing before a State agency on any finding of noncompliance within 60 days after the notice of the intent to impose a remedy. Except in the case of civil money penalties, a request for a hearing shall not delay imposition of the penalty. The choice of remedies is not appealable at a hearing. The level of noncompliance may be challenged only in the case of a civil money penalty. The Illinois Department shall provide by rule for the State agency that will conduct the evidentiary hearings.

The Illinois Department may collect interest on unpaid civil money penalties.

The Illinois Department may adopt all rules necessary to

implement this subsection (I).

(J) The Illinois Department, by rule, may permit individual practitioners to designate that Department payments that may be due the practitioner be made to an alternate payee or alternate payees.

(a) Such alternate payee or alternate payees shall be required to register as an alternate payee in the Medical Assistance Program with the Illinois Department.

(b) If a practitioner designates an alternate payee, the alternate payee and practitioner shall be jointly and severally liable to the Department for payments made to the alternate payee. Pursuant to subsection (E) of this Section, any Department action to suspend or deny payment or recover money or overpayments from an alternate payee shall be subject to an administrative hearing.

(c) Registration as an alternate payee or alternate payees in the Illinois Medical Assistance Program shall be conditional. At any time, the Illinois Department may deny or cancel any alternate payee's registration in the Illinois Medical Assistance Program without cause. Any such denial or cancellation is not subject to an administrative hearing.

(d) The Illinois Department may seek a revocation of any alternate payee, and all owners, officers, and individuals with management responsibility for such alternate payee shall be permanently prohibited from

participating as an owner, an officer, or an individual with management responsibility with an alternate payee in the Illinois Medical Assistance Program, if after reasonable notice and opportunity for a hearing the Illinois Department finds that:

(1) the alternate payee is not complying with the Department's policy or rules and regulations, or with the terms and conditions prescribed by the Illinois Department in its alternate payee registration agreement; or

(2) the alternate payee has failed to keep or make available for inspection, audit, or copying, after receiving a written request from the Illinois Department, such records regarding payments claimed as an alternate payee; or

(3) the alternate payee has failed to furnish any information requested by the Illinois Department regarding payments claimed as an alternate payee; or

(4) the alternate payee has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the Illinois Medical Assistance Program; or

(5) the alternate payee, a person with management responsibility for an alternate payee, an officer or person owning, either directly or indirectly, 5% or

more of the shares of stock or other evidences of ownership in a corporate alternate payee, or a partner in a partnership which is an alternate payee:

(a) was previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of this Code; or

(b) was a person with management responsibility for a vendor previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of this Code, during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion or alternate

payee's revocation; or

(c) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of this Code, during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(d) was an owner of a sole proprietorship or partner in a partnership previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided

under Article V of this Code, during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion or alternate payee's revocation; or

(6) the alternate payee, a person with management responsibility for an alternate payee, an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate alternate payee, or a partner in a partnership which is an alternate payee:

(a) has engaged in conduct prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

(b) was a person with management responsibility for a vendor or alternate payee at the time that the vendor or alternate payee engaged in practices prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

(c) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a vendor or alternate payee at the time such vendor or alternate payee engaged in practices prohibited by applicable federal or State law or regulation

relating to the Illinois Medical Assistance Program; or

(d) was an owner of a sole proprietorship or partner in a partnership which was a vendor or alternate payee at the time such vendor or alternate payee engaged in practices prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

(7) the direct or indirect ownership of the vendor or alternate payee (including the ownership of a vendor or alternate payee that is a partner's interest in a vendor or alternate payee, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor or alternate payee) has been transferred by an individual who is terminated, suspended, or excluded or barred from participating as a vendor or is prohibited or revoked as an alternate payee to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

(K) The Illinois Department of Healthcare and Family Services may withhold payments, in whole or in part, to a provider or alternate payee where there is credible evidence, received from State or federal law enforcement or federal

oversight agencies or from the results of a preliminary Department audit, that the circumstances giving rise to the need for a withholding of payments may involve fraud or willful misrepresentation under the Illinois Medical Assistance program. The Department shall by rule define what constitutes "credible" evidence for purposes of this subsection. The Department may withhold payments without first notifying the provider or alternate payee of its intention to withhold such payments. A provider or alternate payee may request a reconsideration of payment withholding, and the Department must grant such a request. The Department shall state by rule a process and criteria by which a provider or alternate payee may request full or partial release of payments withheld under this subsection. This request may be made at any time after the Department first withholds such payments.

(a) The Illinois Department must send notice of its withholding of program payments within 5 days of taking such action. The notice must set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning its ongoing investigation. The notice must do all of the following:

(1) State that payments are being withheld in accordance with this subsection.

(2) State that the withholding is for a temporary

period, as stated in paragraph (b) of this subsection, and cite the circumstances under which withholding will be terminated.

(3) Specify, when appropriate, which type or types of Medicaid claims withholding is effective.

(4) Inform the provider or alternate payee of the right to submit written evidence for reconsideration of the withholding by the Illinois Department.

(5) Inform the provider or alternate payee that a written request may be made to the Illinois Department for full or partial release of withheld payments and that such requests may be made at any time after the Department first withholds such payments.

(b) All withholding-of-payment actions under this subsection shall be temporary and shall not continue after any of the following:

(1) The Illinois Department or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the provider or alternate payee.

(2) Legal proceedings related to the provider's or alternate payee's alleged fraud, willful misrepresentation, violations of this Act, or violations of the Illinois Department's administrative rules are completed.

(3) The withholding of payments for a period of 3

years.

(c) The Illinois Department may adopt all rules necessary to implement this subsection (K).

(K-5) The Illinois Department may withhold payments, in whole or in part, to a provider or alternate payee upon initiation of an audit, quality of care review, investigation when there is a credible allegation of fraud, or the provider or alternate payee demonstrating a clear failure to cooperate with the Illinois Department such that the circumstances give rise to the need for a withholding of payments. As used in this subsection, "credible allegation" is defined to include an allegation from any source, including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through provider audits, civil actions filed under the Illinois False Claims Act, and law enforcement investigations. An allegation is considered to be credible when it has indicia of reliability. The Illinois Department may withhold payments without first notifying the provider or alternate payee of its intention to withhold such payments. A provider or alternate payee may request a hearing or a reconsideration of payment withholding, and the Illinois Department must grant such a request. The Illinois Department shall state by rule a process and criteria by which a provider or alternate payee may request a hearing or a reconsideration for the full or partial release of payments withheld under this subsection. This request may be made at any time after the

Illinois Department first withholds such payments.

(a) The Illinois Department must send notice of its withholding of program payments within 5 days of taking such action. The notice must set forth the general allegations as to the nature of the withholding action but need not disclose any specific information concerning its ongoing investigation. The notice must do all of the following:

(1) State that payments are being withheld in accordance with this subsection.

(2) State that the withholding is for a temporary period, as stated in paragraph (b) of this subsection, and cite the circumstances under which withholding will be terminated.

(3) Specify, when appropriate, which type or types of claims are withheld.

(4) Inform the provider or alternate payee of the right to request a hearing or a reconsideration of the withholding by the Illinois Department, including the ability to submit written evidence.

(5) Inform the provider or alternate payee that a written request may be made to the Illinois Department for a hearing or a reconsideration for the full or partial release of withheld payments and that such requests may be made at any time after the Illinois Department first withholds such payments.

(b) All withholding of payment actions under this subsection shall be temporary and shall not continue after any of the following:

(1) The Illinois Department determines that there is insufficient evidence of fraud, or the provider or alternate payee demonstrates clear cooperation with the Illinois Department, as determined by the Illinois Department, such that the circumstances do not give rise to the need for withholding of payments; or

(2) The withholding of payments has lasted for a period in excess of 3 years.

(c) The Illinois Department may adopt all rules necessary to implement this subsection (K-5).

(L) The Illinois Department shall establish a protocol to enable health care providers to disclose an actual or potential violation of this Section pursuant to a self-referral disclosure protocol, referred to in this subsection as "the protocol". The protocol shall include direction for health care providers on a specific person, official, or office to whom such disclosures shall be made. The Illinois Department shall post information on the protocol on the Illinois Department's public website. The Illinois Department may adopt rules necessary to implement this subsection (L). In addition to other factors that the Illinois Department finds appropriate, the Illinois Department may consider a health care provider's timely use or failure to use

the protocol in considering the provider's failure to comply with this Code.

(M) Notwithstanding any other provision of this Code, the Illinois Department, at its discretion, may exempt an entity licensed under the Nursing Home Care Act, the ID/DD Community Care Act, or the MC/DD Act from the provisions of subsections (A-15), (B), and (C) of this Section if the licensed entity is in receivership.

(O) Enforcement of advance payment agreements. To the extent not prohibited by federal or State law, and notwithstanding any other provision of this Code, if a provider fails to comply with the terms of an advance payment agreement, the Department is authorized to collect any unpaid advance balance through one or more of the following methods:

(1) Direct withholding of Department reimbursements. The Department may withhold reimbursement or other amounts otherwise payable by the Department to the provider, including, but not limited to, fee-for-service claims payments, supplemental payments, and any other amounts the Department is obligated to pay the provider under the medical assistance program, and apply such withheld amounts as repayment of the unpaid advance.

(2) Managed care organizations remittance. If a provider participates in a managed care program administered by the Department, the Department may direct the managed care organization to remit to the Department

amounts otherwise payable by the managed care organization to the provider, and apply such remitted amounts as repayment of the unpaid advance.

The requirements of this subsection may be waived by the Department in instances when a nursing home provider has entered into and remains in compliance with a renegotiated advance payment agreement. A renegotiated advance payment agreement must be entered into no later than 60 days after the effective date of this amendatory Act of the 104th General Assembly.

A nursing home must enter into a renegotiated advance payment agreement with the Department that includes terms for repayment of the total amount owed for all outstanding amounts over a 12-month period, repaid in equal payment increments. Payments shall begin within 30 days of the signed agreement date.

Failure to remain in compliance with a renegotiated advance payment agreement shall cause immediate termination of such an agreement unless there is prior written consent from the Department for a period of non-compliance.

Beginning September 1, 2026, the Department shall immediately collect all overdue unpaid advance debts through the collection methods authorized under this Section, unless a renegotiated advance payment agreement has already been agreed to.

(Source: P.A. 102-538, eff. 8-20-21.)

ARTICLE 265.

Section 265-5. The State Finance Act is amended by adding Sections 5.1039 and 6z-149 as follows:

(30 ILCS 105/5.1039 new)

Sec. 5.1039. The Staffing Improvement and Long Term Care Oversight Fund.

(30 ILCS 105/6z-149 new)

Sec. 6z-149. The Staffing Improvement and Long Term Care Oversight Fund.

(a) The Staffing Improvement and Long Term Care Oversight Fund is created as a special fund in the State treasury. Interest earned by the Fund shall be credited to the Fund.

(b) Any moneys generated from penalties imposed for non-compliance with minimum staffing standards under Section 3-202.05 of the Nursing Home Care Act shall be deposited into the Fund. Any funds distributed and granted pursuant to this Section shall be contingent on the Department's actual collection of staffing fines under Section 3-202.02 of the Nursing Home Care Act. Beginning in Fiscal Year 2027, funds shall be distributed as follows:

(1) $1,000,000 shall be used in each State fiscal year by the Department of Public Health to train surveyors for

administration of the Bureau of Long Term Care Training. This funding shall not be used to used to replace any other funding appropriated by the General Assembly for this purpose.

(2) 15% of the funding shall be used by the of Public Health to fund Nursing Home Care Act compliance efforts.

(3) $2,000,000 or 50% of the remainder of the moneys deposited under this subsection after the allocations under paragraphs (1) and (2) have been completed, whichever is higher, shall be allocated in each State fiscal year to be ordered transferred by the State Comptroller and transferred by the State Treasurer from the Staffing Improvement and Long Term Care Oversight Fund to be used by the Department to support a Certified Nursing Assistant Workforce Pipeline Program to recruit, support, and train individuals to work as certified nursing assistants at nursing facilities, with a focus on facilities in disadvantaged communities, those serving residents of color, and understaffed facilities. The program shall be administered by a labor-management organization acting on behalf of a partnership between nursing facilities and a labor organization representing nursing home workers. The labor-management organization must demonstrate the ability to recruit, support, train, and place individuals in careers in health care with a specific focus on addressing staff shortages. Program

training and instruction must meet State and federal education regulations and must provide a pathway for participants to receive certification as nursing assistants. Any funds distributed pursuant to this Section shall be compliant with the Grant Accountability and Transparency Act and its regulations, as applicable.

The program may provide supportive services to program participants, including, but not limited to, mentoring and a wraparound support stipend that would cover expenses such as utilities, dependent care, and transportation.

(4) $2,000,000 shall be used in each State fiscal year by the Department of Public Health to administer the identified offenders and other safety activities.

(5) 40% of the remainder of the moneys deposited under this subsection after the allocations under paragraphs (1), (2), (3), and (4) have been completed shall, in each fiscal year, be ordered transferred by the State Comptroller and transferred by the State Treasurer from the Staffing Improvement and Long Term Care Fund to the State Board of Education Special Purposes Trust Fund to be used by the State Board of Education to support the allocation of formula grants for the purposes of supporting programs and coursework that provide vocational training of certified nursing assistants at the secondary level of education, provided that the funds are allocated for the purpose of increasing staffing in Illinois nursing

homes. Entities eligible for award include area career centers and Education for Employment regional CTE systems, as approved by rule of the State Board of Education. Each eligible entity shall receive a formula grant based on student enrollment, credential attainment, and employment. The total appropriation that the State Board of Education receives shall be divided into formula grants proportional to each eligible entity's student participation, credential attainment, and employment according to the following: 50% shall be divided among all entities with students enrolled in all health sciences pathways, 15% shall be divided across all entities with students earning CNA certificates, 20% shall be divided by each student placed at elder care facilities for work-based learning in the prior school year, and 15% shall be divided by the total number of graduates from the prior fiscal year who are employed at elder care facilities. Recipients will provide mid-year and annual reports on templates provided by rhe State Board of Education. Any entity receiving funds under paragraph (3) is not eligible to receive funding under this subsection.

(6) 40% of the remainder of the moneys deposited under this subsection after the allocations under paragraphs (1), (2), (3), and (4) have been completed shall, in each fiscal year, be ordered transferred by the State Comptroller and transferred by the State Treasurer from

the Staffing Improvement and Long Term Care Oversight Fund to the Education Assistance Fund for the Long Term Care Nursing Scholarship Program for scholarships to be awarded to applicants pursuing or intending to pursue employment as a nurse in a licensed nursing home in Illinois. The Illinois Student Assistance Commission shall adopt administrative rules governing the amount, criteria, and award of scholarships to be awarded under this Section.

Section 265-10. The Nursing Home Care Act is amended by changing Section 3-202.05 as follows:

(210 ILCS 45/3-202.05)

Sec. 3-202.05. Staffing ratios effective July 1, 2010 and thereafter.

(a) For the purpose of computing staff to resident ratios, direct care staff shall include:

(1) registered nurses;

(2) licensed practical nurses;

(3) certified nurse assistants;

(4) psychiatric services rehabilitation aides;

(5) rehabilitation and therapy aides;

(6) psychiatric services rehabilitation coordinators;

(7) assistant directors of nursing;

(8) 50% of the Director of Nurses' time; and

(9) 30% of the Social Services Directors' time.

The Department shall, by rule, allow certain facilities subject to 77 Ill. Adm. Code 300.4000 and following (Subpart S) to utilize specialized clinical staff, as defined in rules, to count towards the staffing ratios.

Within 120 days of June 14, 2012 (the effective date of Public Act 97-689), the Department shall promulgate rules specific to the staffing requirements for facilities federally defined as Institutions for Mental Disease. These rules shall recognize the unique nature of individuals with chronic mental health conditions, shall include minimum requirements for specialized clinical staff, including clinical social workers, psychiatrists, psychologists, and direct care staff set forth in paragraphs (4) through (6) and any other specialized staff which may be utilized and deemed necessary to count toward staffing ratios.

Within 120 days of June 14, 2012 (the effective date of Public Act 97-689), the Department shall promulgate rules specific to the staffing requirements for facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013. These rules shall recognize the unique nature of individuals with chronic mental health conditions, shall include minimum requirements for specialized clinical staff, including clinical social workers, psychiatrists, psychologists, and direct care staff set forth in paragraphs (4) through (6) and any other specialized staff which may be utilized and deemed necessary to count toward staffing ratios.

(a-5) The Centers for Medicare and Medicaid Services' payroll-based journal job title codes, which correspond to the staff used for the staffing ratios in subsection (a), are as follows:

(1) Registered Nurse Director of Nursing, job title code 5.

(2) Registered Nurse with Administrative Duties, job title code 6.

(3) Registered Nurse, job title code 7.

(4) Licensed Practical/Vocational Nurse with Administrative Duties, job title code 8.

(5) Licensed Practical/Vocational Nurse, job title code 9.

(6) Certified Nurse Aide, job title code 10.

(7) Nurse Aide in Training, job title code 11.

(8) Medication Aide/Technician, job title code 12.

(9) Nurse Practitioner, job title code 13.

(10) Clinical Nurse Specialist, job title code 14.

(11) Occupational Therapist, job title code 18.

(12) Occupational Therapy Assistant, job title code 19.

(13) Occupational Therapy Aide, job title code 20.

(14) Physical Therapist, job title code 21.

(15) Physical Therapy Assistant, job title code 22.

(16) Physical Therapy Assistant, job title code 23.

(17) Respiratory Therapist, job title code 24.

(18) Respiratory Therapy Technician, job title code 25.

(19) Speech/Language Pathologist, job title code 26.

(20) Qualified Activities Professional, job title code 28.

(21) Other Activities Staff, job title code 29.

(22) Qualified Social Worker, job title code 30.

(23) Other Social Worker, job title code 31.

(24) Mental Health Service Worker, job title code 34.

For all job title codes in this subsection, 100% of the hours worked by the staff must be counted toward the staff-to-resident ratio, except job code title 5, which is limited to 50%, and job title codes 28, 30, and 31, which are limited to 30%.

(b) (Blank).

(b-5) For purposes of the minimum staffing ratios in this Section, all residents shall be classified as requiring either skilled care or intermediate care.

As used in this subsection:

"Intermediate care" means basic nursing care and other restorative services under periodic medical direction.

"Skilled care" means skilled nursing care, continuous skilled nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision.

(c) Facilities shall notify the Department within 60 days

after July 29, 2010 (the effective date of Public Act 96-1372), in a form and manner prescribed by the Department, of the staffing ratios in effect on July 29, 2010 (the effective date of Public Act 96-1372) for both intermediate and skilled care and the number of residents receiving each level of care.

(d)(1) (Blank).

(2) (Blank).

(3) (Blank).

(4) (Blank).

(5) Effective January 1, 2014, the minimum staffing ratios shall be increased to 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and personal care each day for a resident needing intermediate care.

(e) Ninety days after June 14, 2012 (the effective date of Public Act 97-689), a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. These minimum requirements shall remain in effect until an acuity based registered nurse requirement is promulgated by rule concurrent with the adoption of the Resource Utilization Group classification-based payment methodology, as provided in Section 5-5.2 of the Illinois Public Aid Code. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements

may be used to satisfy the remaining 75% of the nursing and personal care time requirements. Notwithstanding this subsection, no staffing requirement in statute in effect on June 14, 2012 (the effective date of Public Act 97-689) shall be reduced on account of this subsection.

(f) The Department shall submit proposed rules for adoption by January 1, 2020 establishing a system for determining compliance with minimum staffing set forth in this Section and the requirements of 77 Ill. Adm. Code 300.1230 adjusted for any waivers granted under Section 3-303.1. Compliance shall be determined quarterly by comparing the number of hours provided per resident per day using the Centers for Medicare and Medicaid Services' payroll-based journal and the facility's daily census, broken down by intermediate and skilled care as self-reported by the facility to the Department on a quarterly basis. The Department shall use the quarterly payroll-based journal and the self-reported census to calculate the number of hours provided per resident per day and compare this ratio to the minimum staffing standards required under this Section, as impacted by any waivers granted under Section 3-303.1. Discrepancies between job titles contained in this Section and the payroll-based journal shall be addressed by rule. The manner in which the Department requests payroll-based journal information to be submitted shall align with the federal Centers for Medicare and Medicaid Services' requirements that allow providers to

submit the quarterly data in an aggregate manner.

(g) Monetary penalties for non-compliance. The Department shall submit proposed rules for adoption by January 1, 2020 establishing monetary penalties for facilities not in compliance with minimum staffing standards under this Section. Facilities shall be required to comply with the provisions of this subsection beginning January 1, 2025. No monetary penalty may be issued for noncompliance prior to the revised implementation date, which shall be January 1, 2025. If a facility is found to be noncompliant prior to the revised implementation date, the Department shall provide a written notice identifying the staffing deficiencies and require the facility to provide a sufficiently detailed correction plan that describes proposed and completed actions the facility will take or has taken, including hiring actions, to address the facility's failure to meet the statutory minimum staffing levels. Monetary penalties shall be imposed beginning no later than July 1, 2025, based on data for the quarter beginning January 1, 2025 through March 31, 2025 and quarterly thereafter. Monetary penalties shall be established based on a formula that calculates on a daily basis the cost of wages and benefits for the missing staffing hours. All notices of noncompliance shall include the computations used to determine noncompliance and establishing the variance between minimum staffing ratios and the Department's computations. The penalty for the first offense shall be 125% of the cost of wages and

benefits for the missing staffing hours. The penalty shall increase to 150% of the cost of wages and benefits for the missing staffing hours for the second offense and 200% the cost of wages and benefits for the missing staffing hours for the third and all subsequent offenses. The penalty shall be imposed regardless of whether the facility has committed other violations of this Act during the same period that the staffing offense occurred. The penalty may not be waived, except where there is no more than a 10% deviation from the staffing requirements, in which case the facility shall not receive a violation or penalty. The Department is granted discretion to waive the violation and penalty when unforeseen circumstances have occurred that resulted in call-offs of scheduled staff. This provision shall be applied no more than 6 times per quarter. Nothing in this Section diminishes a facility's right to appeal the imposition of a monetary penalty. No facility may appeal a notice of noncompliance issued during the revised implementation period. The changes made to this subsection by this amendatory Act of the 104th General Assembly in regard to nursing home staffing fines shall apply to the July 1, 2025 fines based on data for the quarter beginning January 1, 2025 through March 31, 2025 and quarterly thereafter.

Moneys generated from the monetary penalties imposed on facilities that are not in compliance with minimum staffing standards under this subsection and rules adopted under this

subsection shall be deposited into the Staffing Improvement and Long Term Care Oversight Fund and shall be used as provided in Section 6z-149 of the State Finance Act.

(Source: P.A. 104-9, eff. 6-16-25.)

ARTICLE 800.

Section 800-95. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

ARTICLE 999.

Section 999-99. Effective date. This Act takes effect upon becoming law, except that Section 257-10 of Article 257 and Articles 2, 10, 15, and 225 take effect July 1, 2026, and Article 6 takes effect January 1, 2027, and Article 65 takes effect July 1, 2027.