



Rep. Anna Moeller

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1 AMENDMENT TO SENATE BILL 2437

2 AMENDMENT NO. \_\_\_\_\_. Amend Senate Bill 2437 by replacing  
3 everything after the enacting clause with the following:

4 "ARTICLE 2.

5 Section 2-1. Short title. This Article may be cited as the  
6 Certified Family Health Aide Program for Children and Adults  
7 Act. References in this Article to "this Act" mean this  
8 Article.

9 Section 2-5. Purpose. The purpose of this Act is to create  
10 the certified family health aide designation.

11 Section 2-10. Definition. As used in this Act, "certified  
12 family health aide" means a person who:

13 (1) is 18 years of age or older;

14 (2) has the following relationship with the family

1 member receiving or who is eligible to receive the  
2 services enumerated in this Section:

3 (i) spouse;

4 (ii) sibling or stepsibling;

5 (iii) parent, stepparent, or adoptive parent;

6 (iv) grandparent;

7 (v) mother-in-law or father-in-law;

8 (vi) brother-in-law or sister-in-law;

9 (vii) legal guardian; or

10 (viii) caregiver designated by the legally  
11 responsible caregiver as documented in the Medical  
12 Plan of Care;

13 (3) is a legally responsible caregiver, or has been  
14 designated by a legally responsible caregiver, for a  
15 person who receives or is eligible to receive:

16 (i) in-home shift nursing services under the Early  
17 and Periodic Screening, Diagnostic and Treatment  
18 requirement of Medicaid under 42 U.S.C. 1396d(r); or

19 (ii) in-home shift nursing through the home and  
20 community-based services waiver program authorized  
21 under Section 1915(c) of the Social Security Act for  
22 persons who are medically fragile and technology  
23 dependent; and

24 (4) is certified pursuant to this Section to perform  
25 or to assist in performance of services to and for a person  
26 receiving or eligible to receive: (A) in-home shift

1 nursing services under the Early and Periodic Screening,  
2 Diagnostic and Treatment requirement of Medicaid under 42  
3 U.S.C. 1396d(r); or (B) in-home shift nursing services  
4 through the home and community-based services waiver  
5 program authorized under Section 1915(c) of the Social  
6 Security Act for a designated person or designated persons  
7 who are medically fragile and technology dependent and  
8 eligible to receive the services laid out in this Section,  
9 including:

10 (i) the same tasks as a certified nursing  
11 assistant;

12 (ii) medication administration;

13 (iii) enteral care and therapy; and

14 (iv) other needed services to support the  
15 individual as provided by rule.

16 Section 2-15. Certified family health aide program for  
17 children and adults.

18 (a) The Department of Public Health, in partnership with  
19 the Department of Healthcare and Family Services, may create a  
20 certification pathway for a legally responsible caregiver, or  
21 a person who has been designated by a legally responsible  
22 caregiver, who is seeking certification as a certified family  
23 health aide, including the adoption of any necessary rules for  
24 the certification process. This certification pathway shall  
25 include documentation, in a manner designated by the

1 Department of Public Health, of initial training provided by  
2 hospitals licensed in the Hospital Licensing Act, children's  
3 community-based health care centers as defined in the  
4 Alternative Health Care Delivery Act, or home nursing agencies  
5 as defined in the Home Health, Home Services, and Home Nursing  
6 Agency Licensing Act.

7 (b) A certified family health aide may only perform  
8 services to and for a person receiving or eligible to receive:

9 (1) in-home shift nursing services under the Early and  
10 Periodic Screening, Diagnostic and Treatment benefit  
11 requirement of Medicaid under 42 U.S.C. 1396d(r); or

12 (2) in-home shift nursing services through the home  
13 and community-based services waiver program authorized  
14 under Section 1915(c) of the Social Security Act for  
15 persons who are medically fragile and technology  
16 dependent.

17 To be eligible for reimbursement as a certified family  
18 health aide, a legally responsible caregiver or a person  
19 designated by a legally responsible caregiver must meet all  
20 certification requirements as set forth in this Section, in  
21 Section 5-2.06b of Article V of the Illinois Public Aid Code,  
22 and in any applicable administrative rule.

23 (d) The Department of Public Health, in consultation with  
24 the Department of Healthcare and Family Services, may adopt  
25 rules necessary to implement the provisions of this Act,  
26 including, but not limited to, rules requiring background

1 checks for the certified family health aide, establishing the  
2 scope of services a certified family health aide can perform,  
3 and establishing any utilization controls of services  
4 performed by a certified family health aide.

5 Section 2-100. The Alternative Health Care Delivery Act is  
6 amended by changing Section 35 as follows:

7 (210 ILCS 3/35)

8 Sec. 35. Alternative health care models authorized.  
9 Notwithstanding any other law to the contrary, alternative  
10 health care models described in this Section may be  
11 established on a demonstration basis.

12 (1) (Blank).

13 (2) Alternative health care delivery model;  
14 postsurgical recovery care center. A postsurgical recovery  
15 care center is a designated site which provides  
16 postsurgical recovery care for generally healthy patients  
17 undergoing surgical procedures that potentially require  
18 overnight nursing care, pain control, or observation that  
19 would otherwise be provided in an inpatient setting.  
20 Patients may be discharged from the postsurgical recovery  
21 care center in less than 24 hours if the attending  
22 physician or the facility's medical director believes the  
23 patient has recovered enough to be discharged. A  
24 postsurgical recovery care center is either freestanding

1 or a defined unit of an ambulatory surgical treatment  
2 center or hospital. No facility, or portion of a facility,  
3 may participate in a demonstration program as a  
4 postsurgical recovery care center unless the facility has  
5 been licensed as an ambulatory surgical treatment center  
6 or hospital for at least 2 years before August 20, 1993  
7 (the effective date of Public Act 88-441). The maximum  
8 length of stay for patients in a postsurgical recovery  
9 care center is not to exceed 48 hours unless the treating  
10 physician requests an extension of time from the recovery  
11 center's medical director on the basis of medical or  
12 clinical documentation that an additional care period is  
13 required for the recovery of a patient and the medical  
14 director approves the extension of time. In no case,  
15 however, shall a patient's length of stay in a  
16 postsurgical recovery care center be longer than 72 hours.  
17 If a patient requires an additional care period after the  
18 expiration of the 72-hour limit, the patient shall be  
19 transferred to an appropriate facility. Reports on  
20 variances from the 24-hour or 48-hour limit shall be sent  
21 to the Department for its evaluation. The reports shall,  
22 before submission to the Department, have removed from  
23 them all patient and physician identifiers. Blood products  
24 may be administered in the postsurgical recovery care  
25 center model. In order to handle cases of complications,  
26 emergencies, or exigent circumstances, every postsurgical

1 recovery care center as defined in this paragraph shall  
2 maintain a contractual relationship, including a transfer  
3 agreement, with a general acute care hospital. A  
4 postsurgical recovery care center shall be no larger than  
5 20 beds. A postsurgical recovery care center shall be  
6 located within 15 minutes travel time from the general  
7 acute care hospital with which the center maintains a  
8 contractual relationship, including a transfer agreement,  
9 as required under this paragraph.

10 No postsurgical recovery care center shall  
11 discriminate against any patient requiring treatment  
12 because of the source of payment for services, including  
13 Medicare and Medicaid recipients.

14 The Department shall adopt rules to implement the  
15 provisions of Public Act 88-441 concerning postsurgical  
16 recovery care centers within 9 months after August 20,  
17 1993. Notwithstanding any other law to the contrary, a  
18 postsurgical recovery care center model may provide sleep  
19 laboratory or similar sleep studies in accordance with  
20 applicable State and federal laws and regulations.

21 (3) Alternative health care delivery model; children's  
22 community-based health care center. A children's  
23 community-based health care center model is a designated  
24 site that provides nursing care, clinical support  
25 services, and therapies for a period of one to 14 days for  
26 short-term stays and 120 days to facilitate transitions to

1 home or other appropriate settings for medically fragile  
2 children, technology dependent children, and children with  
3 special health care needs who are deemed clinically stable  
4 by a physician and are younger than 22 years of age. This  
5 care is to be provided in a home-like environment that  
6 serves no more than 12 children at a time, except that a  
7 children's community-based health care center in existence  
8 on the effective date of this amendatory Act of the 100th  
9 General Assembly that is located in Chicago on grade level  
10 for Life Safety Code purposes may provide care to no more  
11 than 16 children at a time. Children's community-based  
12 health care center services must be available through the  
13 model to all families, including those whose care is paid  
14 for through the Department of Healthcare and Family  
15 Services, the Department of Children and Family Services,  
16 the Department of Human Services, and insurance companies  
17 who cover home health care services or private duty  
18 nursing care in the home.

19 Each children's community-based health care center  
20 model location shall be physically separate and apart from  
21 any other facility licensed by the Department of Public  
22 Health under this or any other Act and shall provide the  
23 following services: respite care, registered nursing or  
24 licensed practical nursing care, transitional care to  
25 facilitate home placement or other appropriate settings  
26 and reunite families, medical day care, weekend camps, and

1 diagnostic studies typically done in the home setting.

2 A children's community-based health care center may  
3 provide initial training, prior to home placement for, and  
4 shall keep records in a manner designated by the  
5 Department regarding, the certified family health aide, as  
6 defined in the Certified Family Health Aide Program for  
7 Children and Adults Act, identified as the legally  
8 responsible caregiver or designated by a legally  
9 responsible caregiver for the medical care of an  
10 individual who receives or is eligible to receive:

11 (i) in-home shift nursing services under the Early  
12 and Periodic Screening, Diagnostic and Treatment  
13 requirement of Medicaid under 42 U.S.C. 1396d(r); or

14 (ii) in-home shift nursing through the home and  
15 community-based services waiver program authorized  
16 under Section 1915(c) of the Social Security Act for  
17 persons who are medically fragile and technology  
18 dependent.

19 Coverage for the services provided by the Department  
20 of Healthcare and Family Services under this paragraph (3)  
21 is contingent upon federal waiver approval and is provided  
22 only to Medicaid eligible clients participating in the  
23 home and community based services waiver designated in  
24 Section 1915(c) of the Social Security Act for medically  
25 frail and technologically dependent children or children  
26 in Department of Children and Family Services foster care

1 who receive home health benefits.

2 (4) Alternative health care delivery model; community  
3 based residential rehabilitation center. A community-based  
4 residential rehabilitation center model is a designated  
5 site that provides rehabilitation or support, or both, for  
6 persons who have experienced severe brain injury, who are  
7 medically stable, and who no longer require acute  
8 rehabilitative care or intense medical or nursing  
9 services. The average length of stay in a community-based  
10 residential rehabilitation center shall not exceed 4  
11 months. As an integral part of the services provided,  
12 individuals are housed in a supervised living setting  
13 while having immediate access to the community. The  
14 residential rehabilitation center authorized by the  
15 Department may have more than one residence included under  
16 the license. A residence may be no larger than 12 beds and  
17 shall be located as an integral part of the community. Day  
18 treatment or individualized outpatient services shall be  
19 provided for persons who reside in their own home.  
20 Functional outcome goals shall be established for each  
21 individual. Services shall include, but are not limited  
22 to, case management, training and assistance with  
23 activities of daily living, nursing consultation,  
24 traditional therapies (physical, occupational, speech),  
25 functional interventions in the residence and community  
26 (job placement, shopping, banking, recreation),

1 counseling, self-management strategies, productive  
2 activities, and multiple opportunities for skill  
3 acquisition and practice throughout the day. The design of  
4 individualized program plans shall be consistent with the  
5 outcome goals that are established for each resident. The  
6 programs provided in this setting shall be accredited by  
7 the Commission on Accreditation of Rehabilitation  
8 Facilities (CARF). The program shall have been accredited  
9 by CARF as a Brain Injury Community-Integrative Program  
10 for at least 3 years.

11 (5) Alternative health care delivery model;  
12 Alzheimer's disease management center. An Alzheimer's  
13 disease management center model is a designated site that  
14 provides a safe and secure setting for care of persons  
15 diagnosed with Alzheimer's disease. An Alzheimer's disease  
16 management center model shall be a facility separate from  
17 any other facility licensed by the Department of Public  
18 Health under this or any other Act. An Alzheimer's disease  
19 management center shall conduct and document an assessment  
20 of each resident every 6 months. The assessment shall  
21 include an evaluation of daily functioning, cognitive  
22 status, other medical conditions, and behavioral problems.  
23 An Alzheimer's disease management center shall develop and  
24 implement an ongoing treatment plan for each resident. The  
25 treatment plan shall have defined goals. The Alzheimer's  
26 disease management center shall treat behavioral problems

1 and mood disorders using nonpharmacologic approaches such  
2 as environmental modification, task simplification, and  
3 other appropriate activities. All staff must have  
4 necessary training to care for all stages of Alzheimer's  
5 Disease. An Alzheimer's disease management center shall  
6 provide education and support for residents and  
7 caregivers. The education and support shall include  
8 referrals to support organizations for educational  
9 materials on community resources, support groups, legal  
10 and financial issues, respite care, and future care needs  
11 and options. The education and support shall also include  
12 a discussion of the resident's need to make advance  
13 directives and to identify surrogates for medical and  
14 legal decision-making. The provisions of this paragraph  
15 establish the minimum level of services that must be  
16 provided by an Alzheimer's disease management center. An  
17 Alzheimer's disease management center model shall have no  
18 more than 100 residents. Nothing in this paragraph (5)  
19 shall be construed as prohibiting a person or facility  
20 from providing services and care to persons with  
21 Alzheimer's disease as otherwise authorized under State  
22 law.

23 (6) Alternative health care delivery model; birth  
24 center. A birth center shall be exclusively dedicated to  
25 serving the childbirth-related needs of women and their  
26 newborns and shall have no more than 10 beds. A birth

1 center is a designated site that is away from the mother's  
2 usual place of residence and in which births are planned  
3 to occur following a normal, uncomplicated, and low-risk  
4 pregnancy. A birth center shall offer prenatal care and  
5 community education services and shall coordinate these  
6 services with other health care services available in the  
7 community.

8 (A) A birth center shall not be separately  
9 licensed if it is one of the following:

10 (1) A part of a hospital; or

11 (2) A freestanding facility that is physically  
12 distinct from a hospital but is operated under a  
13 license issued to a hospital under the Hospital  
14 Licensing Act.

15 (B) A separate birth center license shall be  
16 required if the birth center is operated as:

17 (1) A part of the operation of a federally  
18 qualified health center as designated by the  
19 United States Department of Health and Human  
20 Services; or

21 (2) A facility other than one described in  
22 subparagraph (A) (1), (A) (2), or (B) (1) of this  
23 paragraph (6) whose costs are reimbursable under  
24 Title XIX of the federal Social Security Act.

25 In adopting rules for birth centers, the Department  
26 shall consider: the American Association of Birth Centers'

1 Standards for Freestanding Birth Centers; the American  
2 Academy of Pediatrics/American College of Obstetricians  
3 and Gynecologists Guidelines for Perinatal Care; and the  
4 Regionalized Perinatal Health Care Code. The Department's  
5 rules shall stipulate the eligibility criteria for birth  
6 center admission. The Department's rules shall stipulate  
7 the necessary equipment for emergency care according to  
8 the American Association of Birth Centers' standards and  
9 any additional equipment deemed necessary by the  
10 Department. The Department's rules shall provide for a  
11 time period within which each birth center not part of a  
12 hospital must become accredited by either the Commission  
13 for the Accreditation of Freestanding Birth Centers or The  
14 Joint Commission.

15 A birth center shall be certified to participate in  
16 the Medicare and Medicaid programs under Titles XVIII and  
17 XIX, respectively, of the federal Social Security Act. To  
18 the extent necessary, the Illinois Department of  
19 Healthcare and Family Services shall apply for a waiver  
20 from the United States Health Care Financing  
21 Administration to allow birth centers to be reimbursed  
22 under Title XIX of the federal Social Security Act.

23 A birth center that is not operated under a hospital  
24 license shall be located within a ground travel time  
25 distance from the general acute care hospital with which  
26 the birth center maintains a contractual relationship,

1 including a transfer agreement, as required under this  
2 paragraph, that allows for an emergency caesarian delivery  
3 to be started within 30 minutes of the decision a  
4 caesarian delivery is necessary. A birth center operating  
5 under a hospital license shall be located within a ground  
6 travel time distance from the licensed hospital that  
7 allows for an emergency caesarian delivery to be started  
8 within 30 minutes of the decision a caesarian delivery is  
9 necessary.

10 The services of a medical director physician, licensed  
11 to practice medicine in all its branches, who is certified  
12 or eligible for certification by the American College of  
13 Obstetricians and Gynecologists or the American Board of  
14 Osteopathic Obstetricians and Gynecologists or has  
15 hospital obstetrical privileges are required in birth  
16 centers. The medical director in consultation with the  
17 Director of Nursing and Midwifery Services shall  
18 coordinate the clinical staff and overall provision of  
19 patient care. The medical director or his or her physician  
20 designee shall be available on the premises or within a  
21 close proximity as defined by rule. The medical director  
22 and the Director of Nursing and Midwifery Services shall  
23 jointly develop and approve policies defining the criteria  
24 to determine which pregnancies are accepted as normal,  
25 uncomplicated, and low-risk, and the anesthesia services  
26 available at the center. No general anesthesia may be

1 administered at the center.

2 If a birth center employs certified nurse midwives, a  
3 certified nurse midwife shall be the Director of Nursing  
4 and Midwifery Services who is responsible for the  
5 development of policies and procedures for services as  
6 provided by Department rules.

7 An obstetrician, family practitioner, or certified  
8 nurse midwife shall attend each woman in labor from the  
9 time of admission through birth and throughout the  
10 immediate postpartum period. Attendance may be delegated  
11 only to another physician or certified nurse midwife.  
12 Additionally, a second staff person shall also be present  
13 at each birth who is licensed or certified in Illinois in a  
14 health-related field and under the supervision of the  
15 physician or certified nurse midwife in attendance, has  
16 specialized training in labor and delivery techniques and  
17 care of newborns, and receives planned and ongoing  
18 training as needed to perform assigned duties effectively.

19 The maximum length of stay in a birth center shall be  
20 consistent with existing State laws allowing a 48-hour  
21 stay or appropriate post-delivery care, if discharged  
22 earlier than 48 hours.

23 A birth center shall participate in the Illinois  
24 Perinatal System under the Developmental Disability  
25 Prevention Act. At a minimum, this participation shall  
26 require a birth center to establish a letter of agreement

1 with a hospital designated under the Perinatal System. A  
2 hospital that operates or has a letter of agreement with a  
3 birth center shall include the birth center under its  
4 maternity service plan under the Hospital Licensing Act  
5 and shall include the birth center in the hospital's  
6 letter of agreement with its regional perinatal center.

7 A birth center may not discriminate against any  
8 patient requiring treatment because of the source of  
9 payment for services, including Medicare and Medicaid  
10 recipients.

11 No general anesthesia and no surgery may be performed  
12 at a birth center. The Department may by rule add birth  
13 center patient eligibility criteria or standards as it  
14 deems necessary. The Department shall by rule require each  
15 birth center to report the information which the  
16 Department shall make publicly available, which shall  
17 include, but is not limited to, the following:

18 (i) Birth center ownership.

19 (ii) Sources of payment for services.

20 (iii) Utilization data involving patient length of  
21 stay.

22 (iv) Admissions and discharges.

23 (v) Complications.

24 (vi) Transfers.

25 (vii) Unusual incidents.

26 (viii) Deaths.

1 (ix) Any other publicly reported data required  
2 under the Illinois Consumer Guide.

3 (x) Post-discharge patient status data where  
4 patients are followed for 14 days after discharge from  
5 the birth center to determine whether the mother or  
6 baby developed a complication or infection.

7 Within 9 months after the effective date of this  
8 amendatory Act of the 95th General Assembly, the  
9 Department shall adopt rules that are developed with  
10 consideration of: the American Association of Birth  
11 Centers' Standards for Freestanding Birth Centers; the  
12 American Academy of Pediatrics/American College of  
13 Obstetricians and Gynecologists Guidelines for Perinatal  
14 Care; and the Regionalized Perinatal Health Care Code.

15 The Department shall adopt other rules as necessary to  
16 implement the provisions of this amendatory Act of the  
17 95th General Assembly within 9 months after the effective  
18 date of this amendatory Act of the 95th General Assembly.

19 (Source: P.A. 100-518, eff. 12-8-17 (see Section 5 of P.A.  
20 100-558 for the effective date of changes made by P.A.  
21 100-518).)

22 Section 2-105. The Home Health, Home Services, and Home  
23 Nursing Agency Licensing Act is amended by changing Section  
24 2.11 and by adding Section 2.13 as follows:

1 (210 ILCS 55/2.11)

2 Sec. 2.11. "Home nursing agency" means an agency that  
3 provides services directly, or acts as a placement agency, in  
4 order to deliver skilled nursing and home health aide services  
5 to persons in their personal residences or a certified family  
6 health aide, as defined by the Certified Family Health Aide  
7 Program for Children and Adults Act, for individuals receiving  
8 or eligible to receive: (1) in-home shift nursing services  
9 under the Early and Periodic Screening, Diagnostic and  
10 Treatment requirement of Medicaid under 42 U.S.C. 1396d(r); or  
11 (2) in-home shift nursing services through the home and  
12 community-based services waiver program authorized under  
13 Section 1915(c) of the Social Security Act for persons who are  
14 medically fragile and technology dependent. A home nursing  
15 agency provides services that would require a licensed nurse  
16 to perform. Home health aide services are provided under the  
17 direction of a registered professional nurse or advanced  
18 practice registered nurse. A home nursing agency does not  
19 require licensure as a home health agency under this Act.  
20 "Home nursing agency" does not include an individually  
21 licensed nurse acting as a private contractor or a person that  
22 provides or procures temporary employment in health care  
23 facilities, as defined in the Nurse Agency Licensing Act.

24 (Source: P.A. 100-513, eff. 1-1-18.)

25 (210 ILCS 55/2.13 new)

1       Sec. 2.13. Certified family health aide. A home nursing  
2 agency may provide initial and ongoing training for, and shall  
3 keep records in a manner designated by the Department  
4 regarding, the certified family health aide, as defined in the  
5 Certified Family Health Aide Program for Children and Adults  
6 Act, identified as the legally responsible caregiver or  
7 designated by the legally responsible caregiver for an  
8 individual who receives or is eligible to receive:

9           (1) in-home shift nursing services under the Early and  
10 Periodic Screening, Diagnostic and Treatment requirement  
11 of Medicaid under 42 U.S.C. 1396d(r); or

12           (2) in-home shift nursing through the home and  
13 community-based services waiver program authorized under  
14 Section 1915(c) of the Social Security Act for persons who  
15 are medically fragile and technology dependent.

16       Section 2-110. The Hospital Licensing Act is amended by  
17 adding Section 17 as follows:

18           (210 ILCS 85/17 new)

19       Sec. 17. Certified family health aide. Hospitals managing  
20 the care of an individual to be discharged under the care of a  
21 home nursing agency may provide initial training, and shall  
22 document in a manner designated by the Department, for the  
23 certified family health aide, as defined in the Certified  
24 Family Health Aide Program for Children and Adults Act,

1 identified as the legally responsible caregiver or designated  
2 by a legally responsible caregiver for an individual who  
3 receives or is eligible to receive: (1) in-home shift nursing  
4 services under the Early and Periodic Screening, Diagnostic  
5 and Treatment requirement of Medicaid under 42 U.S.C. 1396d(r)  
6 or (2) in-home shift nursing through the home and  
7 community-based services waiver program authorized under  
8 Section 1915(c) of the Social Security Act for persons who are  
9 medically fragile and technology dependent.

10 Section 2-115. The Nurse Practice Act is amended by  
11 changing Section 50-15 as follows:

12 (225 ILCS 65/50-15) (was 225 ILCS 65/5-15)

13 (Section scheduled to be repealed on January 1, 2028)

14 Sec. 50-15. Policy; application of Act.

15 (a) For the protection of life and the promotion of  
16 health, and the prevention of illness and communicable  
17 diseases, any person practicing or offering to practice  
18 advanced, professional, or practical nursing in Illinois shall  
19 submit evidence that he or she is qualified to practice, and  
20 shall be licensed as provided under this Act. No person shall  
21 practice or offer to practice advanced, professional, or  
22 practical nursing in Illinois or use any title, sign, card or  
23 device to indicate that such a person is practicing  
24 professional or practical nursing unless such person has been

1 licensed under the provisions of this Act.

2 (b) This Act does not prohibit the following:

3 (1) The practice of nursing in Federal employment in  
4 the discharge of the employee's duties by a person who is  
5 employed by the United States government or any bureau,  
6 division or agency thereof and is a legally qualified and  
7 licensed nurse of another state or territory and not in  
8 conflict with Sections 50-50, 55-10, 60-10, and 70-5 of  
9 this Act.

10 (2) Nursing that is included in the program of study  
11 by students enrolled in programs of nursing or in current  
12 nurse practice update courses approved by the Department.

13 (3) The furnishing of nursing assistance in an  
14 emergency.

15 (4) The practice of nursing by a nurse who holds an  
16 active license in another state when providing services to  
17 patients in Illinois during a bonafide emergency or in  
18 immediate preparation for or during interstate transit.

19 (5) The incidental care of the sick by members of the  
20 family, domestic servants or housekeepers, or care of the  
21 sick where treatment is by prayer or spiritual means.

22 (6) Persons from being employed as unlicensed  
23 assistive personnel in private homes, long term care  
24 facilities, nurseries, hospitals or other institutions.

25 (7) The practice of practical nursing by one who is a  
26 licensed practical nurse under the laws of another U.S.

1 jurisdiction and has applied in writing to the Department,  
2 in form and substance satisfactory to the Department, for  
3 a license as a licensed practical nurse and who is  
4 qualified to receive such license under this Act, until  
5 (i) the expiration of 6 months after the filing of such  
6 written application, (ii) the withdrawal of such  
7 application, or (iii) the denial of such application by  
8 the Department.

9 (8) The practice of advanced practice registered  
10 nursing by one who is an advanced practice registered  
11 nurse under the laws of another United States jurisdiction  
12 or a foreign jurisdiction and has applied in writing to  
13 the Department, in form and substance satisfactory to the  
14 Department, for a license as an advanced practice  
15 registered nurse and who is qualified to receive such  
16 license under this Act, until (i) the expiration of 6  
17 months after the filing of such written application, (ii)  
18 the withdrawal of such application, or (iii) the denial of  
19 such application by the Department.

20 (9) The practice of professional nursing by one who is  
21 a registered professional nurse under the laws of another  
22 United States jurisdiction or a foreign jurisdiction and  
23 has applied in writing to the Department, in form and  
24 substance satisfactory to the Department, for a license as  
25 a registered professional nurse and who is qualified to  
26 receive such license under Section 55-10, until (1) the

1 expiration of 6 months after the filing of such written  
2 application, (2) the withdrawal of such application, or  
3 (3) the denial of such application by the Department.

4 (10) The practice of professional nursing that is  
5 included in a program of study by one who is a registered  
6 professional nurse under the laws of another United States  
7 jurisdiction or a foreign jurisdiction and who is enrolled  
8 in a graduate nursing education program or a program for  
9 the completion of a baccalaureate nursing degree in this  
10 State, which includes clinical supervision by faculty as  
11 determined by the educational institution offering the  
12 program and the health care organization where the  
13 practice of nursing occurs.

14 (11) Any person licensed in this State under any other  
15 Act from engaging in the practice for which she or he is  
16 licensed.

17 (12) Delegation to authorized direct care staff  
18 trained under Section 15.4 of the Mental Health and  
19 Developmental Disabilities Administrative Act consistent  
20 with the policies of the Department.

21 (13) (Blank).

22 (14) County correctional personnel from delivering  
23 prepackaged medication for self-administration to an  
24 individual detainee in a correctional facility.

25 (15) The practice of relevant care by a legally  
26 responsible caregiver or a person designated by a legally

1 responsible caregiver who has been certified as a  
2 certified family health aide, as defined in the Certified  
3 Family Health Aide Program for Children and Adults Act, to  
4 perform for a person who receives or is eligible to  
5 receive: (i) in-home shift nursing services under the  
6 Early and Periodic Screening, Diagnostic and Treatment  
7 requirement of Medicaid under 42 U.S.C. 1396d(r); or (ii)  
8 in-home shift nursing services through the home and  
9 community-based services waiver program authorized under  
10 Section 1915(c) of the Social Security Act for persons who  
11 are medically fragile and technology dependent.

12 Nothing in this Act shall be construed to limit the  
13 delegation of tasks or duties by a physician, dentist, or  
14 podiatric physician to a licensed practical nurse, a  
15 registered professional nurse, or other persons.

16 (Source: P.A. 100-513, eff. 1-1-18.)

17 Section 2-120. The Illinois Public Aid Code is amended by  
18 adding Section 5-2.06b as follows:

19 (305 ILCS 5/5-2.06b new)

20 Sec. 5-2.06b. Certified family health aide program for  
21 children and adults.

22 (a) The Department of Healthcare and Family Services may  
23 seek any federal approval from the Centers for Medicare and  
24 Medicaid Services necessary to reimburse a legally responsible

1 caregiver or a person designated by a legally responsible  
2 caregiver, as defined in the Certified Family Health Aide  
3 Program for Children and Adults Act, who has achieved  
4 certification as a certified family health aide to perform or  
5 assist in performance of services for a person who receives or  
6 is eligible to receive: (1) in-home shift nursing services  
7 under the Early and Periodic Screening, Diagnostic and  
8 Treatment requirement of Medicaid under 42 U.S.C. 1396d(r); or  
9 (2) the home and community-based services waiver program  
10 authorized under Section 1915(c) of the Social Security Act  
11 for a designated person or designated persons who are  
12 medically fragile and technology dependent. Implementation of  
13 any and all parts of the certified family health aide program  
14 is subject to the Department of Healthcare and Family Services  
15 receiving all necessary federal approval. If the Department of  
16 Healthcare and Family Services receives all necessary federal  
17 approval the Department may adopt rules in consultation with  
18 the Department of Public Health to specify the federally  
19 approved services eligible for reimbursement under the  
20 certified family health aide certification and to adopt any  
21 other policies or procedures necessary to implement this  
22 Section.

23 (b) The Department of Healthcare and Family Services, in  
24 partnership with the Department of Public Health, may consult  
25 with stakeholders for expertise regarding implementation of  
26 the certified family health aide program. Stakeholders may

1 include, the University of Illinois at Chicago, Division of  
2 Specialized Care for Children, home nurse agencies, a  
3 physician with medical experience with the population being  
4 served by the program, children's hospitals, a legally  
5 responsible caregiver as described in item (3) of Section 10  
6 of the Certified Family Health Aide Program for Children and  
7 Adults Act, and a Children's Community-Based Health Care  
8 Clinic.

9 (c) Subject to federal approval, the Department of  
10 Healthcare and Family Services may adopt rules to disregard  
11 income earned by a legally responsible caregiver in the  
12 performance of or assisting in the performance of services for  
13 a person receiving or eligible to receive: (1) in-home shift  
14 nursing services under the Early and Periodic Screening,  
15 Diagnostic and Treatment requirement of Medicaid under 42  
16 U.S.C. 1396d(r); or (2) the home and community-based services  
17 waiver program authorized under Section 1915(c) of the Social  
18 Security Act for a designated person or designated persons who  
19 are medically fragile and technology dependent, when  
20 determining the child's eligibility for medical assistance  
21 under the Medical Assistance-No Grant (MANG (AABD)) Income  
22 Standard.

23 ARTICLE 5.

24 Section 5-5. The Illinois Public Aid Code is amended by

1 adding Sections 5-18.6 and 5-18.7 as follows:

2 (305 ILCS 5/5-18.6 new)

3 Sec. 5-18.6. Doula policies; hospitals and birthing  
4 centers.

5 (a) Recognizing the importance that doulas provide in the  
6 support and advocacy for pregnant persons, within 6 months  
7 after this amendatory Act of the 104th General Assembly, all  
8 hospitals with licensed obstetric beds and birthing centers  
9 shall adopt and maintain written policies and procedures to  
10 permit a patient enrolled in the medical assistance program to  
11 have an Illinois Medicaid certified and enrolled doula of the  
12 patient's choice accompany the patient within the facility's  
13 premises for the purposes of providing support before, during,  
14 and after labor and childbirth.

15 (1) An Illinois Medicaid certified and enrolled doula  
16 shall not be counted as a support person or against the  
17 guest quota before, during, or after childbirth.

18 (2) Each applicable facility shall post a summary of  
19 the facility's policies and procedures adopted in  
20 accordance with this subsection on its website, including  
21 contact information to facilitate communication between  
22 the facility and Illinois Medicaid enrolled doulas and  
23 doula organizations.

24 (b) Nothing in this Section shall be construed to provide  
25 a doula with access to a patient when that access is

1 inconsistent with generally accepted medical standards or  
2 practices.

3 (c) Nothing in this Section is intended to expand or limit  
4 the malpractice liability of a hospital beyond the limits  
5 existing in current Illinois statutory and common law;  
6 however, no hospital shall be liable for any act or omission  
7 resulting from the provision of services by any doula solely  
8 on the basis that the hospital permitted an Illinois Medicaid  
9 certified and enrolled doula of the patient's choice to  
10 accompany the patient within the facility's premises for the  
11 purposes of providing support before, during, and after labor  
12 and childbirth. The hospital and Illinois Medicaid certified  
13 and enrolled doula providing care are responsible for their  
14 own acts and omissions.

15 (d) At the request of the hospital or birthing facility,  
16 Illinois Medicaid enrolled doulas must provide written  
17 acknowledgment of Illinois Medicaid doula certification and  
18 enrollment in the medical assistance program.

19 (305 ILCS 5/5-18.7 new)

20 Sec. 5-18.7. Standing recommendations. The Department of  
21 Healthcare and Family Services and the Department of Public  
22 Health may establish standing recommendations to meet Centers  
23 for Medicare and Medicaid Services requirements and ensure  
24 access to preventive services, including Medicaid-covered  
25 maternal and reproductive health supports and services, such

1 as, but not limited to, doulas, lactation consultants, home  
2 visitors, community health workers, and 1115 Waiver services.  
3 No employee of the Department of Healthcare and Family  
4 Services or the Department of Public Health issuing a standing  
5 recommendation in accordance with this Section shall, as a  
6 result of the employee's acts or omissions in issuing the  
7 standing recommendation, be subject to (i) any disciplinary or  
8 other adverse action under the Medical Practice Act of 1987,  
9 (ii) any civil liability, or (iii) any criminal liability.

10 ARTICLE 10.

11 Section 10-5. The Illinois Public Aid Code is amended by  
12 changing Section 5-2 as follows:

13 (305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

14 Sec. 5-2. Classes of persons eligible. Medical assistance  
15 under this Article shall be available to any of the following  
16 classes of persons in respect to whom a plan for coverage has  
17 been submitted to the Governor by the Illinois Department and  
18 approved by him. If changes made in this Section 5-2 require  
19 federal approval, they shall not take effect until such  
20 approval has been received:

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

23 2. Beginning January 1, 2014, persons otherwise

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

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

13 (i) their income, as determined by the  
14 Illinois Department in accordance with any federal  
15 requirements, is equal to or less than 100% of the  
16 federal poverty level; or

17 (ii) their income, after the deduction of  
18 costs incurred for medical care and for other  
19 types of remedial care, is equal to or less than  
20 100% of the federal poverty level.

21 (b) (Blank).

22 3. (Blank).

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

1 expenses.

2 5.(a) Beginning January 1, 2020, individuals during  
3 pregnancy and during the 12-month period beginning on the  
4 last day of the pregnancy, together with their infants,  
5 whose income is at or below 200% of the federal poverty  
6 level. Until September 30, 2019, or sooner if the  
7 maintenance of effort requirements under the Patient  
8 Protection and Affordable Care Act are eliminated or may  
9 be waived before then, individuals during pregnancy and  
10 during the 12-month period beginning on the last day of  
11 the pregnancy, whose countable monthly income, after the  
12 deduction of costs incurred for medical care and for other  
13 types of remedial care as specified in administrative  
14 rule, is equal to or less than the Medical Assistance-No  
15 Grant(C) (MANG(C)) Income Standard in effect on April 1,  
16 2013 as set forth in administrative rule.

17 (b) The plan for coverage shall provide ambulatory  
18 prenatal care to pregnant individuals during a presumptive  
19 eligibility period and establish an income eligibility  
20 standard that is equal to 200% of the federal poverty  
21 level, provided that costs incurred for medical care are  
22 not taken into account in determining such income  
23 eligibility.

24 (c) The Illinois Department may conduct a  
25 demonstration in at least one county that will provide  
26 medical assistance to pregnant individuals together with

1 their infants and children up to one year of age, where the  
2 income eligibility standard is set up to 185% of the  
3 nonfarm income official poverty line, as defined by the  
4 federal Office of Management and Budget. The Illinois  
5 Department shall seek and obtain necessary authorization  
6 provided under federal law to implement such a  
7 demonstration. Such demonstration may establish resource  
8 standards that are not more restrictive than those  
9 established under Article IV of this Code.

10 6. (a) Subject to federal approval, children younger  
11 than age 19 when countable income is at or below 313% of  
12 the federal poverty level, as determined by the Department  
13 and in accordance with all applicable federal  
14 requirements. The Department is authorized to adopt  
15 emergency rules to implement the changes made to this  
16 paragraph by Public Act 102-43. Until September 30, 2019,  
17 or sooner if the maintenance of effort requirements under  
18 the Patient Protection and Affordable Care Act are  
19 eliminated or may be waived before then, children younger  
20 than age 19 whose countable monthly income, after the  
21 deduction of costs incurred for medical care and for other  
22 types of remedial care as specified in administrative  
23 rule, is equal to or less than the Medical Assistance-No  
24 Grant(C) (MANG(C)) Income Standard in effect on April 1,  
25 2013 as set forth in administrative rule.

26 (b) Children and youth who are under temporary custody

1 or guardianship of the Department of Children and Family  
2 Services or who receive financial assistance in support of  
3 an adoption or guardianship placement from the Department  
4 of Children and Family Services.

5 7. (Blank).

6 8. As required under federal law, persons who are  
7 eligible for Transitional Medical Assistance as a result  
8 of an increase in earnings or child or spousal support  
9 received. The plan for coverage for this class of persons  
10 shall:

11 (a) extend the medical assistance coverage to the  
12 extent required by federal law; and

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

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

19 (ii) such coverage shall include all services  
20 covered under Illinois' State Medicaid Plan;

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

23 (iv) such coverage shall be suspended in the  
24 event of a person's failure without good cause to  
25 file in a timely fashion reports required for this  
26 coverage under the Social Security Act and

1 coverage shall be reinstated upon the filing of  
2 such reports if the person remains otherwise  
3 eligible.

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

14 10. Participants in the long-term care insurance  
15 partnership program established under the Illinois  
16 Long-Term Care Partnership Program Act who meet the  
17 qualifications for protection of resources described in  
18 Section 15 of that Act.

19 11. Persons with disabilities who are employed and  
20 eligible for Medicaid, pursuant to Section  
21 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and,  
22 subject to federal approval, persons with a medically  
23 improved disability who are employed and eligible for  
24 Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of  
25 the Social Security Act, as provided by the Illinois  
26 Department by rule. In establishing eligibility standards

1 under this paragraph 11, the Department shall, subject to  
2 federal approval:

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

5 (b) exempt retirement accounts that the person  
6 cannot access without penalty before the age of 59  
7 1/2, and medical savings accounts established pursuant  
8 to 26 U.S.C. 220;

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

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

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

22 (1) persons who have been screened for breast or  
23 cervical cancer under the U.S. Centers for Disease  
24 Control and Prevention Breast and Cervical Cancer  
25 Program established under Title XV of the federal  
26 Public Health Service Act in accordance with the

1 requirements of Section 1504 of that Act as  
2 administered by the Illinois Department of Public  
3 Health; and

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

8 "Medical assistance" under this paragraph 12 shall be  
9 identical to the benefits provided under the State's  
10 approved plan under Title XIX of the Social Security Act.  
11 The Department must request federal approval of the  
12 coverage under this paragraph 12 within 30 days after July  
13 3, 2001 (the effective date of Public Act 92-47).

14 In addition to the persons who are eligible for  
15 medical assistance pursuant to subparagraphs (1) and (2)  
16 of this paragraph 12, and to be paid from funds  
17 appropriated to the Department for its medical programs,  
18 any uninsured person as defined by the Department in rules  
19 residing in Illinois who is younger than 65 years of age,  
20 who has been screened for breast and cervical cancer in  
21 accordance with standards and procedures adopted by the  
22 Department of Public Health for screening, and who is  
23 referred to the Department by the Department of Public  
24 Health as being in need of treatment for breast or  
25 cervical cancer is eligible for medical assistance  
26 benefits that are consistent with the benefits provided to

1 those persons described in subparagraphs (1) and (2).  
2 Medical assistance coverage for the persons who are  
3 eligible under the preceding sentence is not dependent on  
4 federal approval, but federal moneys may be used to pay  
5 for services provided under that coverage upon federal  
6 approval.

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

12 14. Subject to the availability of funds for this  
13 purpose, the Department may provide coverage under this  
14 Article to persons who

15 (a) reside in Illinois; ~~who~~

16 (b) are not eligible under any of the preceding  
17 paragraphs of this Section; ~~and who~~

18 (c) meet the income guidelines of paragraph 2(a)  
19 of this Section; and

20 (d) meet one of the following conditions:

21 (i) have filed an application for asylum  
22 status under 8 U.S.C. 1158 that is pending with  
23 the appropriate federal agency or have a pending  
24 appeal of such an application ~~pending before the~~  
25 ~~federal Department of Homeland Security or on~~  
26 ~~appeal~~ before a court of competent jurisdiction

1 and are represented either by counsel or by an  
2 advocate accredited by the appropriate federal  
3 agency ~~Department of Homeland Security~~ and  
4 employed by a not-for-profit organization in  
5 regard to that application or appeal; ~~or~~

6 (ii) are receiving services through a  
7 federally funded torture treatment center;

8 (iii) have filed a pending application for T  
9 nonimmigrant status pursuant to 8 U.S.C.  
10 1101(a)(15)(T);

11 (iv) have filed a pending application for U  
12 nonimmigrant status pursuant to 8 U.S.C.  
13 1101(a)(15)(U); or

14 (v) have filed as a derivative family member  
15 or are included in the application for item (i),  
16 (iii), or (iv) as provided by Department rule.

17 Medical coverage under this paragraph 14 may be  
18 provided for up to 24 continuous months from the initial  
19 eligibility date so long as an individual continues to  
20 satisfy the criteria of this paragraph 14. If an  
21 individual has an application or appeal pending regarding  
22 an application for asylum, T nonimmigrant status, or U  
23 nonimmigrant status before the appropriate federal agency  
24 for such applications or appeals ~~Department of Homeland~~  
25 ~~Security~~, eligibility under this paragraph 14 may be  
26 extended until a final decision is rendered with respect

1       to the application or appeal, except that an individual  
2       who is approved for a U visa continues to qualify for  
3       medical coverage under this paragraph 14 as long as the  
4       individual meets all other eligibility criteria ~~on the~~  
5       ~~appeal~~. The Department shall ~~may~~ adopt rules governing the  
6       implementation of this paragraph 14.

7             15. Family Care Eligibility.

8             (a) On and after July 1, 2012, a parent or other  
9       caretaker relative who is 19 years of age or older when  
10       countable income is at or below 133% of the federal  
11       poverty level. A person may not spend down to become  
12       eligible under this paragraph 15.

13            (b) Eligibility shall be reviewed annually.

14            (c) (Blank).

15            (d) (Blank).

16            (e) (Blank).

17            (f) (Blank).

18            (g) (Blank).

19            (h) (Blank).

20            (i) Following termination of an individual's  
21       coverage under this paragraph 15, the individual must  
22       be determined eligible before the person can be  
23       re-enrolled.

24            16. Subject to appropriation, uninsured persons who  
25       are not otherwise eligible under this Section who have  
26       been certified and referred by the Department of Public

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

1 Security Act. Notwithstanding any other provision of law,  
2 the Department (i) does not have a claim against the  
3 estate of a deceased recipient of services under this  
4 paragraph 16 and (ii) does not have a lien against any  
5 homestead property or other legal or equitable real  
6 property interest owned by a recipient of services under  
7 this paragraph 16.

8 17. Persons who, pursuant to a waiver approved by the  
9 Secretary of the U.S. Department of Health and Human  
10 Services, are eligible for medical assistance under Title  
11 XIX or XXI of the federal Social Security Act.  
12 Notwithstanding any other provision of this Code and  
13 consistent with the terms of the approved waiver, the  
14 Illinois Department, may by rule:

15 (a) Limit the geographic areas in which the waiver  
16 program operates.

17 (b) Determine the scope, quantity, duration, and  
18 quality, and the rate and method of reimbursement, of  
19 the medical services to be provided, which may differ  
20 from those for other classes of persons eligible for  
21 assistance under this Article.

22 (c) Restrict the persons' freedom in choice of  
23 providers.

24 18. Beginning January 1, 2014, persons aged 19 or  
25 older, but younger than 65, who are not otherwise eligible  
26 for medical assistance under this Section 5-2, who qualify

1 for medical assistance pursuant to 42 U.S.C.  
2 1396a(a)(10)(A)(i)(VIII) and applicable federal  
3 regulations, and who have income at or below 133% of the  
4 federal poverty level plus 5% for the applicable family  
5 size as determined pursuant to 42 U.S.C. 1396a(e)(14) and  
6 applicable federal regulations. Persons eligible for  
7 medical assistance under this paragraph 18 shall receive  
8 coverage for the Health Benefits Service Package as that  
9 term is defined in subsection (m) of Section 5-1.1 of this  
10 Code. If Illinois' federal medical assistance percentage  
11 (FMAP) is reduced below 90% for persons eligible for  
12 medical assistance under this paragraph 18, eligibility  
13 under this paragraph 18 shall cease no later than the end  
14 of the third month following the month in which the  
15 reduction in FMAP takes effect.

16 19. Beginning January 1, 2014, as required under 42  
17 U.S.C. 1396a(a)(10)(A)(i)(IX), persons older than age 18  
18 and younger than age 26 who are not otherwise eligible for  
19 medical assistance under paragraphs (1) through (17) of  
20 this Section who (i) were in foster care under the  
21 responsibility of the State on the date of attaining age  
22 18 or on the date of attaining age 21 when a court has  
23 continued wardship for good cause as provided in Section  
24 2-31 of the Juvenile Court Act of 1987 and (ii) received  
25 medical assistance under the Illinois Title XIX State Plan  
26 or waiver of such plan while in foster care.

1           20. (Blank). ~~Beginning January 1, 2018, persons who~~  
2 ~~are foreign born victims of human trafficking, torture, or~~  
3 ~~other serious crimes as defined in Section 2-19 of this~~  
4 ~~Code and their derivative family members if such persons:~~  
5 ~~(i) reside in Illinois; (ii) are not eligible under any of~~  
6 ~~the preceding paragraphs; (iii) meet the income guidelines~~  
7 ~~of subparagraph (a) of paragraph 2; and (iv) meet the~~  
8 ~~nonfinancial eligibility requirements of Sections 16-2,~~  
9 ~~16-3, and 16-5 of this Code. The Department may extend~~  
10 ~~medical assistance for persons who are foreign born~~  
11 ~~victims of human trafficking, torture, or other serious~~  
12 ~~crimes whose medical assistance would be terminated~~  
13 ~~pursuant to subsection (b) of Section 16-5 if the~~  
14 ~~Department determines that the person, during the year of~~  
15 ~~initial eligibility (1) experienced a health crisis, (2)~~  
16 ~~has been unable, after reasonable attempts, to obtain~~  
17 ~~necessary information from a third party, or (3) has other~~  
18 ~~extenuating circumstances that prevented the person from~~  
19 ~~completing his or her application for status. The~~  
20 ~~Department may adopt any rules necessary to implement the~~  
21 ~~provisions of this paragraph.~~

22           21. Persons who are not otherwise eligible for medical  
23 assistance under this Section who may qualify for medical  
24 assistance pursuant to 42 U.S.C.  
25 1396a(a)(10)(A)(ii)(XXIII) and 42 U.S.C. 1396(ss) for the  
26 duration of any federal or State declared emergency due to

1 COVID-19. Medical assistance to persons eligible for  
2 medical assistance solely pursuant to this paragraph 21  
3 shall be limited to any in vitro diagnostic product (and  
4 the administration of such product) described in 42 U.S.C.  
5 1396d(a)(3)(B) on or after March 18, 2020, any visit  
6 described in 42 U.S.C. 1396o(a)(2)(G), or any other  
7 medical assistance that may be federally authorized for  
8 this class of persons. The Department may also cover  
9 treatment of COVID-19 for this class of persons, or any  
10 similar category of uninsured individuals, to the extent  
11 authorized under a federally approved 1115 Waiver or other  
12 federal authority. Notwithstanding the provisions of  
13 Section 1-11 of this Code, due to the nature of the  
14 COVID-19 public health emergency, the Department may cover  
15 and provide the medical assistance described in this  
16 paragraph 21 to noncitizens who would otherwise meet the  
17 eligibility requirements for the class of persons  
18 described in this paragraph 21 for the duration of the  
19 State emergency period.

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

1 Services, unless the Department is provided with express  
2 statutory authority.

3 The eligibility of any such person for medical assistance  
4 under this Article is not affected by the payment of any grant  
5 under the Senior Citizens and Persons with Disabilities  
6 Property Tax Relief Act or any distributions or items of  
7 income described under subparagraph (X) of paragraph (2) of  
8 subsection (a) of Section 203 of the Illinois Income Tax Act.

9 The Department shall by rule establish the amounts of  
10 assets to be disregarded in determining eligibility for  
11 medical assistance, which shall at a minimum equal the amounts  
12 to be disregarded under the Federal Supplemental Security  
13 Income Program. The amount of assets of a single person to be  
14 disregarded shall not be less than \$2,000, and the amount of  
15 assets of a married couple to be disregarded shall not be less  
16 than \$3,000.

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

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

1 benefits.

2 Notwithstanding any other provision of this Code, if the  
3 United States Supreme Court holds Title II, Subtitle A,  
4 Section 2001(a) of Public Law 111-148 to be unconstitutional,  
5 or if a holding of Public Law 111-148 makes Medicaid  
6 eligibility allowed under Section 2001(a) inoperable, the  
7 State or a unit of local government shall be prohibited from  
8 enrolling individuals in the Medical Assistance Program as the  
9 result of federal approval of a State Medicaid waiver on or  
10 after June 14, 2012 (the effective date of Public Act 97-687),  
11 and any individuals enrolled in the Medical Assistance Program  
12 pursuant to eligibility permitted as a result of such a State  
13 Medicaid waiver shall become immediately ineligible.

14 Notwithstanding any other provision of this Code, if an  
15 Act of Congress that becomes a Public Law eliminates Section  
16 2001(a) of Public Law 111-148, the State or a unit of local  
17 government shall be prohibited from enrolling individuals in  
18 the Medical Assistance Program as the result of federal  
19 approval of a State Medicaid waiver on or after June 14, 2012  
20 (the effective date of Public Act 97-687), and any individuals  
21 enrolled in the Medical Assistance Program pursuant to  
22 eligibility permitted as a result of such a State Medicaid  
23 waiver shall become immediately ineligible.

24 Effective October 1, 2013, the determination of  
25 eligibility of persons who qualify under paragraphs 5, 6, 8,  
26 15, 17, and 18 of this Section shall comply with the

1 requirements of 42 U.S.C. 1396a(e)(14) and applicable federal  
2 regulations.

3 The Department of Healthcare and Family Services, the  
4 Department of Human Services, and the Illinois health  
5 insurance marketplace shall work cooperatively to assist  
6 persons who would otherwise lose health benefits as a result  
7 of changes made under Public Act 98-104 to transition to other  
8 health insurance coverage.

9 (Source: P.A. 101-10, eff. 6-5-19; 101-649, eff. 7-7-20;  
10 102-43, eff. 7-6-21; 102-558, eff. 8-20-21; 102-665, eff.  
11 10-8-21; 102-813, eff. 5-13-22.)

12 ARTICLE 15.

13 Section 15-5. The Illinois Public Aid Code is amended by  
14 changing Section 5-5.09a as follows:

15 (305 ILCS 5/5-5.09a new)

16 Sec. 5-5.09a. Screening for tardive dyskinesia.

17 (a) Notwithstanding any other provisions of law, the  
18 Department of Healthcare and Family Services shall develop, in  
19 collaboration with the Department of Human Services and the  
20 Department of Public Health, recommended screening guidelines  
21 for tardive dyskinesia for providers serving patients  
22 prescribed antipsychotic medications under the medical  
23 assistance program in State-operated residential facilities

1 and community-based settings.

2 (b) The recommended screening guidelines shall be based on  
3 current, nationally accepted, evidence-based recommendations  
4 for the assessment and treatment of tardive dyskinesia, and  
5 shall include structured assessment tools, which can be both  
6 quantitative and qualitative.

7 (c) The Department of Healthcare and Family Services and  
8 the Department of Human Services, in collaboration with the  
9 Department of Public Health, shall develop communication  
10 strategies and educational materials to be offered to health  
11 care providers regarding tardive dyskinesia, the recommended  
12 screening guidelines, and any subsequent revisions. In  
13 developing the information to be disseminated under this  
14 Section, the Departments of Healthcare and Family Services,  
15 Human Services, and Public Health shall consult with a  
16 statewide association representing physicians licensed to  
17 practice medicine in all its branches and a statewide  
18 association representing psychiatrists.

19 ARTICLE 20.

20 Section 20-5. The Illinois Public Aid Code is amended by  
21 changing Section 5-5.12f as follows:

22 (305 ILCS 5/5-5.12f)

23 Sec. 5-5.12f. Prescription drugs for mental illness; no

1 utilization or prior approval mandates.

2 (a) Notwithstanding any other provision of this Code to  
3 the contrary, except as otherwise provided in subsection (b),  
4 for the purpose of removing barriers to the timely treatment  
5 of serious mental illnesses, prior authorization mandates and  
6 utilization management controls shall not be imposed under the  
7 fee-for-service and managed care medical assistance programs  
8 on any FDA-approved prescription drug that is recognized by a  
9 generally accepted standard medical reference as effective in  
10 the treatment of conditions specified in the most recent  
11 Diagnostic and Statistical Manual of Mental Disorders  
12 published by the American Psychiatric Association if a  
13 preferred or non-preferred drug is prescribed to an adult  
14 patient to treat serious mental illness and one of the  
15 following applies:

16 (1) the patient has changed providers, including, but  
17 not limited to, a change from an inpatient to an  
18 outpatient provider, and is stable on the drug that has  
19 been previously prescribed, and received prior  
20 authorization, if required;

21 (2) the patient has changed Medical assistance program  
22 or managed care plan ~~insurance~~ coverage and is stable on  
23 the drug that has been previously prescribed and received  
24 prior authorization under the previous source of coverage;  
25 or

26 (3) subject to federal law on maximum dosage limits

1 and safety edits adopted by the Department's Drug and  
2 Therapeutics Board, including those safety edits and  
3 limits needed to comply with federal requirements  
4 contained in 42 CFR 456.703, the patient has previously  
5 been prescribed and obtained prior authorization for the  
6 drug and the prescription modifies the dosage, dosage  
7 frequency, or both, of the drug as part of the same  
8 treatment for which the drug was previously prescribed.

9 (b) The following safety edits shall be permitted for  
10 prescription drugs covered under this Section:

11 (1) clinically appropriate drug utilization review  
12 (DUR) edits, including, but not limited to, drug-to-drug,  
13 drug-age, and drug-dose;

14 (2) generic drug substitution if a generic drug is  
15 available for the prescribed medication in the same dosage  
16 and formulation; and

17 (3) any utilization management control that is  
18 necessary for the Department to comply with any current  
19 consent decrees or federal waivers.

20 (c) As used in this Section, "serious mental illness"  
21 means any one or more of the following diagnoses and  
22 International Classification of Diseases, Tenth Revision,  
23 Clinical Modification (ICD-10-CM) codes listed by the  
24 Department of Human Services' Division of Mental Health, as  
25 amended, on its official website:

26 (1) Delusional Disorder (F22)

- 1 (2) Brief Psychotic Disorder (F23)
- 2 (3) Schizophreniform Disorder (F20.81)
- 3 (4) Schizophrenia (F20.9)
- 4 (5) Schizoaffective Disorder (F25.x)
- 5 (6) Catatonia Associated with Another Mental Disorder
- 6 (Catatonia Specifier) (F06.1)
- 7 (7) Other Specified Schizophrenia Spectrum and Other
- 8 Psychotic Disorder (F28)
- 9 (8) Unspecified Schizophrenia Spectrum and Other
- 10 Psychotic Disorder (F29)
- 11 (9) Bipolar I Disorder (F31.xx)
- 12 (10) Bipolar II Disorder (F31.81)
- 13 (11) Cyclothymic Disorder (F34.0)
- 14 (12) Unspecified Bipolar and Related Disorder (F31.9)
- 15 (13) Disruptive Mood Dysregulation Disorder (F34.8)
- 16 (14) Major Depressive Disorder Single episode (F32.xx)
- 17 (15) Major Depressive Disorder, Recurrent episode
- 18 (F33.xx)
- 19 (16) Obsessive-Compulsive Disorder (F42)
- 20 (17) Posttraumatic Stress Disorder (F43.10)
- 21 (18) Anorexia Nervosa (F50.0x)
- 22 (19) Bulimia Nervosa (F50.2)
- 23 (20) Postpartum Depression (F53.0)
- 24 (21) Puerperal Psychosis (F53.1)
- 25 (22) Factitious Disorder Imposed on Another (F68.A)
- 26 (d) Notwithstanding any other provision of law, nothing in

1 this Section shall not be construed to conflict with Section  
2 1927(a)(1) and (b)(1)(A) of the federal Social Security Act  
3 and any implementing regulations and agreements.

4 (e) The Department shall publish a report semi-annually on  
5 its website on compliance with the conditions of this Section  
6 by the fee-for-service program and managed care organizations  
7 beginning with dates of service on and after July 1, 2025.  
8 These reports shall be due 12 months after the end of the  
9 period to be reported. These reports shall include:

10 (1) The number of clinically denied prescriptions  
11 summarized by each of the allowed categories specified in  
12 subsection (b). This paragraph shall include the number of  
13 prior authorization denials.

14 (2) The number of clinically denied prescriptions as  
15 summarized by each of the nonallowed categories specified  
16 in subsection (a), categorized by denial reason.

17 (3) The number of prior authorizations of  
18 prescriptions contrary to the prohibition described in  
19 subsection (a).

20 (4) The number of complaints filed concerning denials  
21 for prescriptions, which meet the conditions specified in  
22 subsection (a).

23 (5) The number of approved and paid prescriptions  
24 described in subsection (a) and the potential net cost to  
25 the State.

26 (6) The number of persons enrolled in the medical

1 assistance program using emergency room services based on  
2 categories specified in subsection (c) as the primary  
3 diagnosis for the emergency room visit.

4 (7) The number of persons admitted into a hospital and  
5 the number of hospital readmissions, based on categories  
6 specified in subsection (c) as the primary diagnosis for  
7 the hospital admission or readmission.

8 As used in this Section, "net cost" means the difference  
9 in total ingredient cost due to changes in product mix plus  
10 total loss in aggregate rebate revenue based on product mix  
11 realized in Fiscal Year 2025. Nothing in this Section shall  
12 require the Department to disclose information that is exempt  
13 from disclosure under paragraph (g) of subsection (1) of  
14 Section 7 of the Freedom of Information Act.

15 For purposes of this Section, a hospital readmission  
16 occurs when a patient is discharged from a hospital and then  
17 admitted into the same or another hospital within 30 days of  
18 discharge for the same primary diagnosis.

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

20 ARTICLE 30.

21 Section 30-5. The Illinois Public Aid Code is amended by  
22 changing Section 5-2b as follows:

23 (305 ILCS 5/5-2b)

1           Sec. 5-2b. Medically fragile and technology dependent  
2 children eligibility and program; provider reimbursement  
3 rates.

4           (a) Notwithstanding any other provision of law except as  
5 provided in Section 5-30a, on and after September 1, 2012,  
6 subject to federal approval, medical assistance under this  
7 Article shall be available to children who qualify as persons  
8 with a disability, as defined under the federal Supplemental  
9 Security Income program and who are medically fragile and  
10 technology dependent. The program shall allow eligible  
11 children to receive the medical assistance provided under this  
12 Article in the community and must maximize, to the fullest  
13 extent permissible under federal law, federal reimbursement  
14 and family cost-sharing, including co-pays, premiums, or any  
15 other family contributions, except that the Department shall  
16 be permitted to incentivize the utilization of selected  
17 services through the use of cost-sharing adjustments. The  
18 Department shall establish the policies, procedures,  
19 standards, services, and criteria for this program by rule.

20           (b) Notwithstanding any other provision of this Code,  
21 subject to federal approval, on and after January 1, 2024, the  
22 reimbursement rates for nursing paid through Nursing and  
23 Personal Care Services for non-waiver customers and to  
24 providers of private duty nursing services for children  
25 eligible for medical assistance under this Section shall be  
26 20% higher than the reimbursement rates in effect for nursing

1 services on December 31, 2023.

2 (c) Notwithstanding any other provision of this Code,  
3 subject to federal approval, on and after January 1, 2025, the  
4 reimbursement rates for nursing paid through Nursing and  
5 Personal Care Services for non-waiver customers and to  
6 providers of private duty nursing services for children  
7 eligible for medical assistance under this Section shall be 7%  
8 higher than the reimbursement rates in effect for nursing  
9 services on December 31, 2024.

10 (d) The Department shall conduct an evaluation to study  
11 the program, including service provision and design, waiver  
12 operations, and methodologies and policies for setting rates  
13 and reimbursements for services and supports that are provided  
14 to (i) individuals under the age of 21 who are approved by the  
15 Department for in-home shift nursing services and (ii)  
16 individuals over the age of 21 who are receiving in-home shift  
17 nursing services under the Home and Community-Based Services  
18 Waiver for Medically Fragile and Technology Dependent  
19 Children, including, but not limited to, in-home shift nursing  
20 services and related home and community-based services and  
21 supports, made to nursing agencies for such services. As  
22 needed, the Department shall consult with Department-enrolled  
23 providers of in-home shift nursing services to ensure accurate  
24 information is considered in the evaluation, and the  
25 Department may, to the extent it deems necessary and  
26 appropriate, contract with an outside entity to assist or

1 provide further analysis in the support of the evaluation.

2 (Source: P.A. 103-102, eff. 1-1-24; 103-593, eff. 6-7-24.)

3 ARTICLE 35.

4 Section 35-5. The Illinois Public Aid Code is amended by  
5 adding Section 5-65 as follows:

6 (305 ILCS 5/5-65 new)

7 Sec. 5-65. Reimbursement rates for long-term  
8 electrocardiogram monitoring.

9 (a) As used in this Section, "long-term ambulatory  
10 electrocardiogram monitoring services" means the provision of  
11 external cardiac patch monitoring devices to patients to wear  
12 for 48 hours or greater and the interpretation of data  
13 gathered by such devices to detect heart arrhythmias that can  
14 lead to stroke, cardiac arrest, or other comorbidities or  
15 medical complications if not correctly diagnosed.

16 (b) Subject to federal approval, for dates of service on  
17 and after January 1, 2026, the Department shall reimburse  
18 diagnostic testing facilities that provide long-term  
19 ambulatory electrocardiogram monitoring services at a rate not  
20 less than 80% of the Medicare Physician Fee Schedule rate in  
21 effect for such services on the effective date of this  
22 amendatory Act of the 104th General Assembly.

1 ARTICLE 40.

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

4 (305 ILCS 5/5-5)

5 (Text of Section before amendment by P.A. 103-808)

6 Sec. 5-5. Medical services. The Illinois Department, by  
7 rule, shall determine the quantity and quality of and the rate  
8 of reimbursement for the medical assistance for which payment  
9 will be authorized, and the medical services to be provided,  
10 which may include all or part of the following: (1) inpatient  
11 hospital services; (2) outpatient hospital services; (3) other  
12 laboratory and X-ray services; (4) skilled nursing home  
13 services; (5) physicians' services whether furnished in the  
14 office, the patient's home, a hospital, a skilled nursing  
15 home, or elsewhere; (6) medical care, or any other type of  
16 remedial care furnished by licensed practitioners; (7) home  
17 health care services; (8) private duty nursing service; (9)  
18 clinic services; (10) dental services, including prevention  
19 and treatment of periodontal disease and dental caries disease  
20 for pregnant individuals, provided by an individual licensed  
21 to practice dentistry or dental surgery; for purposes of this  
22 item (10), "dental services" means diagnostic, preventive, or  
23 corrective procedures provided by or under the supervision of  
24 a dentist in the practice of his or her profession; (11)

1 physical therapy and related services; (12) prescribed drugs,  
2 dentures, and prosthetic devices; and eyeglasses prescribed by  
3 a physician skilled in the diseases of the eye, or by an  
4 optometrist, whichever the person may select; (13) other  
5 diagnostic, screening, preventive, and rehabilitative  
6 services, including to ensure that the individual's need for  
7 intervention or treatment of mental disorders or substance use  
8 disorders or co-occurring mental health and substance use  
9 disorders is determined using a uniform screening, assessment,  
10 and evaluation process inclusive of criteria, for children and  
11 adults; for purposes of this item (13), a uniform screening,  
12 assessment, and evaluation process refers to a process that  
13 includes an appropriate evaluation and, as warranted, a  
14 referral; "uniform" does not mean the use of a singular  
15 instrument, tool, or process that all must utilize; (14)  
16 transportation and such other expenses as may be necessary;  
17 (15) medical treatment of sexual assault survivors, as defined  
18 in Section 1a of the Sexual Assault Survivors Emergency  
19 Treatment Act, for injuries sustained as a result of the  
20 sexual assault, including examinations and laboratory tests to  
21 discover evidence which may be used in criminal proceedings  
22 arising from the sexual assault; (16) the diagnosis and  
23 treatment of sickle cell anemia; (16.5) services performed by  
24 a chiropractic physician licensed under the Medical Practice  
25 Act of 1987 and acting within the scope of his or her license,  
26 including, but not limited to, chiropractic manipulative

1 treatment; and (17) any other medical care, and any other type  
2 of remedial care recognized under the laws of this State. The  
3 term "any other type of remedial care" shall include nursing  
4 care and nursing home service for persons who rely on  
5 treatment by spiritual means alone through prayer for healing.

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

13 Notwithstanding any other provision of this Code,  
14 reproductive health care that is otherwise legal in Illinois  
15 shall be covered under the medical assistance program for  
16 persons who are otherwise eligible for medical assistance  
17 under this Article.

18 Notwithstanding any other provision of this Section, all  
19 tobacco cessation medications approved by the United States  
20 Food and Drug Administration and all individual and group  
21 tobacco cessation counseling services and telephone-based  
22 counseling services and tobacco cessation medications provided  
23 through the Illinois Tobacco Quitline shall be covered under  
24 the medical assistance program for persons who are otherwise  
25 eligible for assistance under this Article. The Department  
26 shall comply with all federal requirements necessary to obtain

1 federal financial participation, as specified in 42 CFR  
2 433.15(b)(7), for telephone-based counseling services provided  
3 through the Illinois Tobacco Quitline, including, but not  
4 limited to: (i) entering into a memorandum of understanding or  
5 interagency agreement with the Department of Public Health, as  
6 administrator of the Illinois Tobacco Quitline; and (ii)  
7 developing a cost allocation plan for Medicaid-allowable  
8 Illinois Tobacco Quitline services in accordance with 45 CFR  
9 95.507. The Department shall submit the memorandum of  
10 understanding or interagency agreement, the cost allocation  
11 plan, and all other necessary documentation to the Centers for  
12 Medicare and Medicaid Services for review and approval.  
13 Coverage under this paragraph shall be contingent upon federal  
14 approval.

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

22 Upon receipt of federal approval of an amendment to the  
23 Illinois Title XIX State Plan for this purpose, the Department  
24 shall authorize the Chicago Public Schools (CPS) to procure a  
25 vendor or vendors to manufacture eyeglasses for individuals  
26 enrolled in a school within the CPS system. CPS shall ensure

1 that its vendor or vendors are enrolled as providers in the  
2 medical assistance program and in any capitated Medicaid  
3 managed care entity (MCE) serving individuals enrolled in a  
4 school within the CPS system. Under any contract procured  
5 under this provision, the vendor or vendors must serve only  
6 individuals enrolled in a school within the CPS system. Claims  
7 for services provided by CPS's vendor or vendors to recipients  
8 of benefits in the medical assistance program under this Code,  
9 the Children's Health Insurance Program, or the Covering ALL  
10 KIDS Health Insurance Program shall be submitted to the  
11 Department or the MCE in which the individual is enrolled for  
12 payment and shall be reimbursed at the Department's or the  
13 MCE's established rates or rate methodologies for eyeglasses.

14 On and after July 1, 2012, the Department of Healthcare  
15 and Family Services may provide the following services to  
16 persons eligible for assistance under this Article who are  
17 participating in education, training or employment programs  
18 operated by the Department of Human Services as successor to  
19 the Department of Public Aid:

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

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

25 On and after July 1, 2018, the Department of Healthcare  
26 and Family Services shall provide dental services to any adult

1 who is otherwise eligible for assistance under the medical  
2 assistance program. As used in this paragraph, "dental  
3 services" means diagnostic, preventative, restorative, or  
4 corrective procedures, including procedures and services for  
5 the prevention and treatment of periodontal disease and dental  
6 caries disease, provided by an individual who is licensed to  
7 practice dentistry or dental surgery or who is under the  
8 supervision of a dentist in the practice of his or her  
9 profession.

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

20 Subject to federal approval, on and after January 1, 2025,  
21 the rates paid for sedation evaluation and the provision of  
22 deep sedation and intravenous sedation for the purpose of  
23 dental services shall be increased by 33% above the rates in  
24 effect on December 31, 2024. The rates paid for nitrous oxide  
25 sedation shall not be impacted by this paragraph and shall  
26 remain the same as the rates in effect on December 31, 2024.

1           Notwithstanding any other provision of this Code and  
2           subject to federal approval, the Department may adopt rules to  
3           allow a dentist who is volunteering his or her service at no  
4           cost to render dental services through an enrolled  
5           not-for-profit health clinic without the dentist personally  
6           enrolling as a participating provider in the medical  
7           assistance program. A not-for-profit health clinic shall  
8           include a public health clinic or Federally Qualified Health  
9           Center or other enrolled provider, as determined by the  
10          Department, through which dental services covered under this  
11          Section are performed. The Department shall establish a  
12          process for payment of claims for reimbursement for covered  
13          dental services rendered under this provision.

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

18          On and after January 1, 2022, the Department of Healthcare  
19          and Family Services shall administer and regulate a  
20          school-based dental program that allows for the out-of-office  
21          delivery of preventative dental services in a school setting  
22          to children under 19 years of age. The Department shall  
23          establish, by rule, guidelines for participation by providers  
24          and set requirements for follow-up referral care based on the  
25          requirements established in the Dental Office Reference Manual  
26          published by the Department that establishes the requirements

1 for dentists participating in the All Kids Dental School  
2 Program. Every effort shall be made by the Department when  
3 developing the program requirements to consider the different  
4 geographic differences of both urban and rural areas of the  
5 State for initial treatment and necessary follow-up care. No  
6 provider shall be charged a fee by any unit of local government  
7 to participate in the school-based dental program administered  
8 by the Department. Nothing in this paragraph shall be  
9 construed to limit or preempt a home rule unit's or school  
10 district's authority to establish, change, or administer a  
11 school-based dental program in addition to, or independent of,  
12 the school-based dental program administered by the  
13 Department.

14 The Illinois Department, by rule, may distinguish and  
15 classify the medical services to be provided only in  
16 accordance with the classes of persons designated in Section  
17 5-2.

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

25 The Illinois Department shall authorize the provision of,  
26 and shall authorize payment for, screening by low-dose

1 mammography for the presence of occult breast cancer for  
2 individuals 35 years of age or older who are eligible for  
3 medical assistance under this Article, as follows:

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

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

8 (C) A mammogram at the age and intervals considered  
9 medically necessary by the individual's health care  
10 provider for individuals under 40 years of age and having  
11 a family history of breast cancer, prior personal history  
12 of breast cancer, positive genetic testing, or other risk  
13 factors.

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

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

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

26 The Department shall not impose a deductible, coinsurance,

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

8 All screenings shall include a physical breast exam,  
9 instruction on self-examination and information regarding the  
10 frequency of self-examination and its value as a preventative  
11 tool.

12 For purposes of this Section:

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

15 "Diagnostic mammography" means a method of screening that  
16 is designed to evaluate an abnormality in a breast, including  
17 an abnormality seen or suspected on a screening mammogram or a  
18 subjective or objective abnormality otherwise detected in the  
19 breast.

20 "Low-dose mammography" means the x-ray examination of the  
21 breast using equipment dedicated specifically for mammography,  
22 including the x-ray tube, filter, compression device, and  
23 image receptor, with an average radiation exposure delivery of  
24 less than one rad per breast for 2 views of an average size  
25 breast. The term also includes digital mammography and  
26 includes breast tomosynthesis.

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

5 If, at any time, the Secretary of the United States  
6 Department of Health and Human Services, or its successor  
7 agency, promulgates rules or regulations to be published in  
8 the Federal Register or publishes a comment in the Federal  
9 Register or issues an opinion, guidance, or other action that  
10 would require the State, pursuant to any provision of the  
11 Patient Protection and Affordable Care Act (Public Law  
12 111-148), including, but not limited to, 42 U.S.C.  
13 18031(d)(3)(B) or any successor provision, to defray the cost  
14 of any coverage for breast tomosynthesis outlined in this  
15 paragraph, then the requirement that an insurer cover breast  
16 tomosynthesis is inoperative other than any such coverage  
17 authorized under Section 1902 of the Social Security Act, 42  
18 U.S.C. 1396a, and the State shall not assume any obligation  
19 for the cost of coverage for breast tomosynthesis set forth in  
20 this paragraph.

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

26 On and after January 1, 2012, providers participating in a

1 quality improvement program approved by the Department shall  
2 be reimbursed for screening and diagnostic mammography at the  
3 same rate as the Medicare program's rates, including the  
4 increased reimbursement for digital mammography and, after  
5 January 1, 2023 (the effective date of Public Act 102-1018),  
6 breast tomosynthesis.

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

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

17 The Department shall convene an expert panel, including  
18 representatives of hospitals, free-standing breast cancer  
19 treatment centers, breast cancer quality organizations, and  
20 doctors, including breast surgeons, reconstructive breast  
21 surgeons, oncologists, and primary care providers to establish  
22 quality standards for breast cancer treatment.

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

1 hospital-based mammography facilities. By January 1, 2016, the  
2 Department shall report to the General Assembly on the status  
3 of the provision set forth in this paragraph.

4 The Department shall establish a methodology to remind  
5 individuals who are age-appropriate for screening mammography,  
6 but who have not received a mammogram within the previous 18  
7 months, of the importance and benefit of screening  
8 mammography. The Department shall work with experts in breast  
9 cancer outreach and patient navigation to optimize these  
10 reminders and shall establish a methodology for evaluating  
11 their effectiveness and modifying the methodology based on the  
12 evaluation.

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

19 The Department shall devise a means of case-managing or  
20 patient navigation for beneficiaries diagnosed with breast  
21 cancer. This program shall initially operate as a pilot  
22 program in areas of the State with the highest incidence of  
23 mortality related to breast cancer. At least one pilot program  
24 site shall be in the metropolitan Chicago area and at least one  
25 site shall be outside the metropolitan Chicago area. On or  
26 after July 1, 2016, the pilot program shall be expanded to

1 include one site in western Illinois, one site in southern  
2 Illinois, one site in central Illinois, and 4 sites within  
3 metropolitan Chicago. An evaluation of the pilot program shall  
4 be carried out measuring health outcomes and cost of care for  
5 those served by the pilot program compared to similarly  
6 situated patients who are not served by the pilot program.

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

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

26 On or after July 1, 2022, individuals who are otherwise

1 eligible for medical assistance under this Article shall  
2 receive coverage for perinatal depression screenings for the  
3 12-month period beginning on the last day of their pregnancy.  
4 Medical assistance coverage under this paragraph shall be  
5 conditioned on the use of a screening instrument approved by  
6 the Department.

7 Any medical or health care provider shall immediately  
8 recommend, to any pregnant individual who is being provided  
9 prenatal services and is suspected of having a substance use  
10 disorder as defined in the Substance Use Disorder Act,  
11 referral to a local substance use disorder treatment program  
12 licensed by the Department of Human Services or to a licensed  
13 hospital which provides substance abuse treatment services.  
14 The Department of Healthcare and Family Services shall assure  
15 coverage for the cost of treatment of the drug abuse or  
16 addiction for pregnant recipients in accordance with the  
17 Illinois Medicaid Program in conjunction with the Department  
18 of Human Services.

19 All medical providers providing medical assistance to  
20 pregnant individuals under this Code shall receive information  
21 from the Department on the availability of services under any  
22 program providing case management services for addicted  
23 individuals, including information on appropriate referrals  
24 for other social services that may be needed by addicted  
25 individuals in addition to treatment for addiction.

26 The Illinois Department, in cooperation with the

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

8 Neither the Department of Healthcare and Family Services  
9 nor the Department of Human Services shall sanction the  
10 recipient solely on the basis of the recipient's substance  
11 abuse.

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

21 The Illinois Department may develop and contract with  
22 Partnerships of medical providers to arrange medical services  
23 for persons eligible under Section 5-2 of this Code.  
24 Implementation of this Section may be by demonstration  
25 projects in certain geographic areas. The Partnership shall be  
26 represented by a sponsor organization. The Department, by

1 rule, shall develop qualifications for sponsors of  
2 Partnerships. Nothing in this Section shall be construed to  
3 require that the sponsor organization be a medical  
4 organization.

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

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

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

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

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

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

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

22 The Illinois Department shall require health care  
23 providers to maintain records that document the medical care  
24 and services provided to recipients of Medical Assistance  
25 under this Article. Such records must be retained for a period  
26 of not less than 6 years from the date of service or as

1 provided by applicable State law, whichever period is longer,  
2 except that if an audit is initiated within the required  
3 retention period then the records must be retained until the  
4 audit is completed and every exception is resolved. The  
5 Illinois Department shall require health care providers to  
6 make available, when authorized by the patient, in writing,  
7 the medical records in a timely fashion to other health care  
8 providers who are treating or serving persons eligible for  
9 Medical Assistance under this Article. All dispensers of  
10 medical services shall be required to maintain and retain  
11 business and professional records sufficient to fully and  
12 accurately document the nature, scope, details and receipt of  
13 the health care provided to persons eligible for medical  
14 assistance under this Code, in accordance with regulations  
15 promulgated by the Illinois Department. The rules and  
16 regulations shall require that proof of the receipt of  
17 prescription drugs, dentures, prosthetic devices and  
18 eyeglasses by eligible persons under this Section accompany  
19 each claim for reimbursement submitted by the dispenser of  
20 such medical services. No such claims for reimbursement shall  
21 be approved for payment by the Illinois Department without  
22 such proof of receipt, unless the Illinois Department shall  
23 have put into effect and shall be operating a system of  
24 post-payment audit and review which shall, on a sampling  
25 basis, be deemed adequate by the Illinois Department to assure  
26 that such drugs, dentures, prosthetic devices and eyeglasses

1 for which payment is being made are actually being received by  
2 eligible recipients. Within 90 days after September 16, 1984  
3 (the effective date of Public Act 83-1439), the Illinois  
4 Department shall establish a current list of acquisition costs  
5 for all prosthetic devices and any other items recognized as  
6 medical equipment and supplies reimbursable under this Article  
7 and shall update such list on a quarterly basis, except that  
8 the acquisition costs of all prescription drugs shall be  
9 updated no less frequently than every 30 days as required by  
10 Section 5-5.12.

11 Notwithstanding any other law to the contrary, the  
12 Illinois Department shall, within 365 days after July 22, 2013  
13 (the effective date of Public Act 98-104), establish  
14 procedures to permit skilled care facilities licensed under  
15 the Nursing Home Care Act to submit monthly billing claims for  
16 reimbursement purposes. Following development of these  
17 procedures, the Department shall, by July 1, 2016, test the  
18 viability of the new system and implement any necessary  
19 operational or structural changes to its information  
20 technology platforms in order to allow for the direct  
21 acceptance and payment of nursing home claims.

22 Notwithstanding any other law to the contrary, the  
23 Illinois Department shall, within 365 days after August 15,  
24 2014 (the effective date of Public Act 98-963), establish  
25 procedures to permit ID/DD facilities licensed under the ID/DD  
26 Community Care Act and MC/DD facilities licensed under the

1 MC/DD Act to submit monthly billing claims for reimbursement  
2 purposes. Following development of these procedures, the  
3 Department shall have an additional 365 days to test the  
4 viability of the new system and to ensure that any necessary  
5 operational or structural changes to its information  
6 technology platforms are implemented.

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

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

24 Enrollment of a vendor shall be subject to a provisional  
25 period and shall be conditional for one year. During the  
26 period of conditional enrollment, the Department may terminate

1 the vendor's eligibility to participate in, or may disenroll  
2 the vendor from, the medical assistance program without cause.  
3 Unless otherwise specified, such termination of eligibility or  
4 disenrollment is not subject to the Department's hearing  
5 process. However, a disenrolled vendor may reapply without  
6 penalty.

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

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

22 The Department shall define or specify the following: (i)  
23 by provider notice, the "category of risk of the vendor" for  
24 each type of vendor, which shall take into account the level of  
25 screening applicable to a particular category of vendor under  
26 federal law and regulations; (ii) by rule or provider notice,

1 the maximum length of the conditional enrollment period for  
2 each category of risk of the vendor; and (iii) by rule, the  
3 hearing rights, if any, afforded to a vendor in each category  
4 of risk of the vendor that is terminated or disenrolled during  
5 the conditional enrollment period.

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

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

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

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

25 (4) In the case of a provider operated by a unit of  
26 local government with a population exceeding 3,000,000

1           when local government funds finance federal participation  
2           for claims payments.

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

10          In the case of long term care facilities, within 120  
11 calendar days of receipt by the facility of required  
12 prescreening information, new admissions with associated  
13 admission documents shall be submitted through the Medical  
14 Electronic Data Interchange (MEDI) or the Recipient  
15 Eligibility Verification (REV) System or shall be submitted  
16 directly to the Department of Human Services using required  
17 admission forms. Effective September 1, 2014, admission  
18 documents, including all prescreening information, must be  
19 submitted through MEDI or REV. Confirmation numbers assigned  
20 to an accepted transaction shall be retained by a facility to  
21 verify timely submittal. Once an admission transaction has  
22 been completed, all resubmitted claims following prior  
23 rejection are subject to receipt no later than 180 days after  
24 the admission transaction has been completed.

25          Claims that are not submitted and received in compliance  
26 with the foregoing requirements shall not be eligible for

1 payment under the medical assistance program, and the State  
2 shall have no liability for payment of those claims.

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

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

1 the Illinois Department shall enter into agreements with State  
2 agencies and departments, and is authorized to enter into  
3 agreements with federal agencies and departments, including,  
4 but not limited to: the Secretary of State; the Department of  
5 Revenue; the Department of Public Health; the Department of  
6 Human Services; and the Department of Financial and  
7 Professional Regulation.

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

22 The Illinois Department shall establish policies,  
23 procedures, standards and criteria by rule for the  
24 acquisition, repair and replacement of orthotic and prosthetic  
25 devices and durable medical equipment. Such rules shall  
26 provide, but not be limited to, the following services: (1)

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

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

25 In order to promote environmental responsibility, meet the  
26 needs of recipients and enrollees, and achieve significant

1 cost savings, the Department, or a managed care organization  
2 under contract with the Department, may provide recipients or  
3 managed care enrollees who have a prescription or Certificate  
4 of Medical Necessity access to refurbished durable medical  
5 equipment under this Section (excluding prosthetic and  
6 orthotic devices as defined in the Orthotics, Prosthetics, and  
7 Pedorthics Practice Act and complex rehabilitation technology  
8 products and associated services) through the State's  
9 assistive technology program's reutilization program, using  
10 staff with the Assistive Technology Professional (ATP)  
11 Certification if the refurbished durable medical equipment:  
12 (i) is available; (ii) is less expensive, including shipping  
13 costs, than new durable medical equipment of the same type;  
14 (iii) is able to withstand at least 3 years of use; (iv) is  
15 cleaned, disinfected, sterilized, and safe in accordance with  
16 federal Food and Drug Administration regulations and guidance  
17 governing the reprocessing of medical devices in health care  
18 settings; and (v) equally meets the needs of the recipient or  
19 enrollee. The reutilization program shall confirm that the  
20 recipient or enrollee is not already in receipt of the same or  
21 similar equipment from another service provider, and that the  
22 refurbished durable medical equipment equally meets the needs  
23 of the recipient or enrollee. Nothing in this paragraph shall  
24 be construed to limit recipient or enrollee choice to obtain  
25 new durable medical equipment or place any additional prior  
26 authorization conditions on enrollees of managed care

1 organizations.

2 The Department shall execute, relative to the nursing home  
3 prescreening project, written inter-agency agreements with the  
4 Department of Human Services and the Department on Aging, to  
5 effect the following: (i) intake procedures and common  
6 eligibility criteria for those persons who are receiving  
7 non-institutional services; and (ii) the establishment and  
8 development of non-institutional services in areas of the  
9 State where they are not currently available or are  
10 undeveloped; and (iii) notwithstanding any other provision of  
11 law, subject to federal approval, on and after July 1, 2012, an  
12 increase in the determination of need (DON) scores from 29 to  
13 37 for applicants for institutional and home and  
14 community-based long term care; if and only if federal  
15 approval is not granted, the Department may, in conjunction  
16 with other affected agencies, implement utilization controls  
17 or changes in benefit packages to effectuate a similar savings  
18 amount for this population; and (iv) no later than July 1,  
19 2013, minimum level of care eligibility criteria for  
20 institutional and home and community-based long term care; and  
21 (v) no later than October 1, 2013, establish procedures to  
22 permit long term care providers access to eligibility scores  
23 for individuals with an admission date who are seeking or  
24 receiving services from the long term care provider. In order  
25 to select the minimum level of care eligibility criteria, the  
26 Governor shall establish a workgroup that includes affected

1 agency representatives and stakeholders representing the  
2 institutional and home and community-based long term care  
3 interests. This Section shall not restrict the Department from  
4 implementing lower level of care eligibility criteria for  
5 community-based services in circumstances where federal  
6 approval has been granted.

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

14 The Illinois Department shall report annually to the  
15 General Assembly, no later than the second Friday in April of  
16 1979 and each year thereafter, in regard to:

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

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

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

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

25 The period covered by each report shall be the 3 years  
26 ending on the June 30 prior to the report. The report shall

1 include suggested legislation for consideration by the General  
2 Assembly. The requirement for reporting to the General  
3 Assembly shall be satisfied by filing copies of the report as  
4 required by Section 3.1 of the General Assembly Organization  
5 Act, and filing such additional copies with the State  
6 Government Report Distribution Center for the General Assembly  
7 as is required under paragraph (t) of Section 7 of the State  
8 Library Act.

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

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

20 Because kidney transplantation can be an appropriate,  
21 cost-effective alternative to renal dialysis when medically  
22 necessary and notwithstanding the provisions of Section 1-11  
23 of this Code, beginning October 1, 2014, the Department shall  
24 cover kidney transplantation for noncitizens with end-stage  
25 renal disease who are not eligible for comprehensive medical  
26 benefits, who meet the residency requirements of Section 5-3

1 of this Code, and who would otherwise meet the financial  
2 requirements of the appropriate class of eligible persons  
3 under Section 5-2 of this Code. To qualify for coverage of  
4 kidney transplantation, such person must be receiving  
5 emergency renal dialysis services covered by the Department.  
6 Providers under this Section shall be prior approved and  
7 certified by the Department to perform kidney transplantation  
8 and the services under this Section shall be limited to  
9 services associated with kidney transplantation.

10 Notwithstanding any other provision of this Code to the  
11 contrary, on or after July 1, 2015, all FDA-approved ~~FDA~~  
12 ~~approved~~ forms of medication assisted treatment prescribed for  
13 the treatment of alcohol dependence or treatment of opioid  
14 dependence shall be covered under both fee-for-service and  
15 managed care medical assistance programs for persons who are  
16 otherwise eligible for medical assistance under this Article  
17 and shall not be subject to any (1) utilization control, other  
18 than those established under the American Society of Addiction  
19 Medicine patient placement criteria, (2) prior authorization  
20 mandate, (3) lifetime restriction limit mandate, or (4)  
21 limitations on dosage.

22 On or after July 1, 2015, opioid antagonists prescribed  
23 for the treatment of an opioid overdose, including the  
24 medication product, administration devices, and any pharmacy  
25 fees or hospital fees related to the dispensing, distribution,  
26 and administration of the opioid antagonist, shall be covered

1 under the medical assistance program for persons who are  
2 otherwise eligible for medical assistance under this Article.  
3 As used in this Section, "opioid antagonist" means a drug that  
4 binds to opioid receptors and blocks or inhibits the effect of  
5 opioids acting on those receptors, including, but not limited  
6 to, naloxone hydrochloride or any other similarly acting drug  
7 approved by the U.S. Food and Drug Administration. The  
8 Department shall not impose a copayment on the coverage  
9 provided for naloxone hydrochloride under the medical  
10 assistance program.

11 Upon federal approval, the Department shall provide  
12 coverage and reimbursement for all drugs that are approved for  
13 marketing by the federal Food and Drug Administration and that  
14 are recommended by the federal Public Health Service or the  
15 United States Centers for Disease Control and Prevention for  
16 pre-exposure prophylaxis and related pre-exposure prophylaxis  
17 services, including, but not limited to, HIV and sexually  
18 transmitted infection screening, treatment for sexually  
19 transmitted infections, medical monitoring, assorted labs, and  
20 counseling to reduce the likelihood of HIV infection among  
21 individuals who are not infected with HIV but who are at high  
22 risk of HIV infection.

23 A federally qualified health center, as defined in Section  
24 1905(1)(2)(B) of the federal Social Security Act, shall be  
25 reimbursed by the Department in accordance with the federally  
26 qualified health center's encounter rate for services provided

1 to medical assistance recipients that are performed by a  
2 dental hygienist, as defined under the Illinois Dental  
3 Practice Act, working under the general supervision of a  
4 dentist and employed by a federally qualified health center.

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

12 Subject to approval by the federal Centers for Medicare  
13 and Medicaid Services of a Title XIX State Plan amendment  
14 electing the Program of All-Inclusive Care for the Elderly  
15 (PACE) as a State Medicaid option, as provided for by Subtitle  
16 I (commencing with Section 4801) of Title IV of the Balanced  
17 Budget Act of 1997 (Public Law 105-33) and Part 460  
18 (commencing with Section 460.2) of Subchapter E of Title 42 of  
19 the Code of Federal Regulations, PACE program services shall  
20 become a covered benefit of the medical assistance program,  
21 subject to criteria established in accordance with all  
22 applicable laws.

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

1 Palliative Care Act.

2       Notwithstanding any other provision of this Code, within  
3 12 months after June 2, 2022 (the effective date of Public Act  
4 102-1037) and subject to federal approval, acupuncture  
5 services performed by an acupuncturist licensed under the  
6 Acupuncture Practice Act who is acting within the scope of his  
7 or her license shall be covered under the medical assistance  
8 program. The Department shall apply for any federal waiver or  
9 State Plan amendment, if required, to implement this  
10 paragraph. The Department may adopt any rules, including  
11 standards and criteria, necessary to implement this paragraph.

12       Notwithstanding any other provision of this Code, the  
13 medical assistance program shall, subject to federal approval,  
14 reimburse hospitals for costs associated with a newborn  
15 screening test for the presence of metachromatic  
16 leukodystrophy, as required under the Newborn Metabolic  
17 Screening Act, at a rate not less than the fee charged by the  
18 Department of Public Health. Notwithstanding any other  
19 provision of this Code, the medical assistance program shall,  
20 subject to appropriation and federal approval, also reimburse  
21 hospitals for costs associated with all newborn screening  
22 tests added on and after August 9, 2024 (the effective date of  
23 Public Act 103-909) ~~this amendatory Act of the 103rd General~~  
24 ~~Assembly~~ to the Newborn Metabolic Screening Act and required  
25 to be performed under that Act at a rate not less than the fee  
26 charged by the Department of Public Health. The Department

1 shall seek federal approval before the implementation of the  
2 newborn screening test fees by the Department of Public  
3 Health.

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

12 Notwithstanding any other provision of this Code,  
13 medically necessary reconstructive services that are intended  
14 to restore physical appearance shall be covered under the  
15 medical assistance program for persons who are otherwise  
16 eligible for medical assistance under this Article. As used in  
17 this paragraph, "reconstructive services" means treatments  
18 performed on structures of the body damaged by trauma to  
19 restore physical appearance.

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

24 (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;  
25 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article  
26 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,

1 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;  
2 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.  
3 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;  
4 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.  
5 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;  
6 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.  
7 1-1-24; 103-593, Article 5, Section 5-5, eff. 6-7-24; 103-593,  
8 Article 90, Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24;  
9 103-909, eff. 8-9-24; 103-1040, eff. 8-9-24; revised  
10 10-10-24.)

11 (Text of Section after amendment by P.A. 103-808)

12 Sec. 5-5. Medical services. The Illinois Department, by  
13 rule, shall determine the quantity and quality of and the rate  
14 of reimbursement for the medical assistance for which payment  
15 will be authorized, and the medical services to be provided,  
16 which may include all or part of the following: (1) inpatient  
17 hospital services; (2) outpatient hospital services; (3) other  
18 laboratory and X-ray services; (4) skilled nursing home  
19 services; (5) physicians' services whether furnished in the  
20 office, the patient's home, a hospital, a skilled nursing  
21 home, or elsewhere; (6) medical care, or any other type of  
22 remedial care furnished by licensed practitioners; (7) home  
23 health care services; (8) private duty nursing service; (9)  
24 clinic services; (10) dental services, including prevention  
25 and treatment of periodontal disease and dental caries disease

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

1 arising from the sexual assault; (16) the diagnosis and  
2 treatment of sickle cell anemia; (16.5) services performed by  
3 a chiropractic physician licensed under the Medical Practice  
4 Act of 1987 and acting within the scope of his or her license,  
5 including, but not limited to, chiropractic manipulative  
6 treatment; and (17) any other medical care, and any other type  
7 of remedial care recognized under the laws of this State. The  
8 term "any other type of remedial care" shall include nursing  
9 care and nursing home service for persons who rely on  
10 treatment by spiritual means alone through prayer for healing.

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

18 Notwithstanding any other provision of this Code,  
19 reproductive health care that is otherwise legal in Illinois  
20 shall be covered under the medical assistance program for  
21 persons who are otherwise eligible for medical assistance  
22 under this Article.

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

1 counseling services and tobacco cessation medications provided  
2 through the Illinois Tobacco Quitline shall be covered under  
3 the medical assistance program for persons who are otherwise  
4 eligible for assistance under this Article. The Department  
5 shall comply with all federal requirements necessary to obtain  
6 federal financial participation, as specified in 42 CFR  
7 433.15(b) (7), for telephone-based counseling services provided  
8 through the Illinois Tobacco Quitline, including, but not  
9 limited to: (i) entering into a memorandum of understanding or  
10 interagency agreement with the Department of Public Health, as  
11 administrator of the Illinois Tobacco Quitline; and (ii)  
12 developing a cost allocation plan for Medicaid-allowable  
13 Illinois Tobacco Quitline services in accordance with 45 CFR  
14 95.507. The Department shall submit the memorandum of  
15 understanding or interagency agreement, the cost allocation  
16 plan, and all other necessary documentation to the Centers for  
17 Medicare and Medicaid Services for review and approval.  
18 Coverage under this paragraph shall be contingent upon federal  
19 approval.

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

1           Upon receipt of federal approval of an amendment to the  
2 Illinois Title XIX State Plan for this purpose, the Department  
3 shall authorize the Chicago Public Schools (CPS) to procure a  
4 vendor or vendors to manufacture eyeglasses for individuals  
5 enrolled in a school within the CPS system. CPS shall ensure  
6 that its vendor or vendors are enrolled as providers in the  
7 medical assistance program and in any capitated Medicaid  
8 managed care entity (MCE) serving individuals enrolled in a  
9 school within the CPS system. Under any contract procured  
10 under this provision, the vendor or vendors must serve only  
11 individuals enrolled in a school within the CPS system. Claims  
12 for services provided by CPS's vendor or vendors to recipients  
13 of benefits in the medical assistance program under this Code,  
14 the Children's Health Insurance Program, or the Covering ALL  
15 KIDS Health Insurance Program shall be submitted to the  
16 Department or the MCE in which the individual is enrolled for  
17 payment and shall be reimbursed at the Department's or the  
18 MCE's established rates or rate methodologies for eyeglasses.

19           On and after July 1, 2012, the Department of Healthcare  
20 and Family Services may provide the following services to  
21 persons eligible for assistance under this Article who are  
22 participating in education, training or employment programs  
23 operated by the Department of Human Services as successor to  
24 the Department of Public Aid:

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

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

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

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

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

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

6 Notwithstanding any other provision of this Code and  
7 subject to federal approval, the Department may adopt rules to  
8 allow a dentist who is volunteering his or her service at no  
9 cost to render dental services through an enrolled  
10 not-for-profit health clinic without the dentist personally  
11 enrolling as a participating provider in the medical  
12 assistance program. A not-for-profit health clinic shall  
13 include a public health clinic or Federally Qualified Health  
14 Center or other enrolled provider, as determined by the  
15 Department, through which dental services covered under this  
16 Section are performed. The Department shall establish a  
17 process for payment of claims for reimbursement for covered  
18 dental services rendered under this provision.

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

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

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

19 The Illinois Department, by rule, may distinguish and  
20 classify the medical services to be provided only in  
21 accordance with the classes of persons designated in Section  
22 5-2.

23 The Department of Healthcare and Family Services must  
24 provide coverage and reimbursement for amino acid-based  
25 elemental formulas, regardless of delivery method, for the  
26 diagnosis and treatment of (i) eosinophilic disorders and (ii)

1 short bowel syndrome when the prescribing physician has issued  
2 a written order stating that the amino acid-based elemental  
3 formula is medically necessary.

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

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

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

13 (C) A mammogram at the age and intervals considered  
14 medically necessary by the individual's health care  
15 provider for individuals under 40 years of age and having  
16 a family history of breast cancer, prior personal history  
17 of breast cancer, positive genetic testing, or other risk  
18 factors.

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

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

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

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

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

19          All screenings shall include a physical breast exam,  
20          instruction on self-examination and information regarding the  
21          frequency of self-examination and its value as a preventative  
22          tool.

23          For purposes of this Section:

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

26          "Diagnostic mammography" means a method of screening that

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

5 "Low-dose mammography" means the x-ray examination of the  
6 breast using equipment dedicated specifically for mammography,  
7 including the x-ray tube, filter, compression device, and  
8 image receptor, with an average radiation exposure delivery of  
9 less than one rad per breast for 2 views of an average size  
10 breast. The term also includes digital mammography and  
11 includes breast tomosynthesis.

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

16 If, at any time, the Secretary of the United States  
17 Department of Health and Human Services, or its successor  
18 agency, promulgates rules or regulations to be published in  
19 the Federal Register or publishes a comment in the Federal  
20 Register or issues an opinion, guidance, or other action that  
21 would require the State, pursuant to any provision of the  
22 Patient Protection and Affordable Care Act (Public Law  
23 111-148), including, but not limited to, 42 U.S.C.  
24 18031(d)(3)(B) or any successor provision, to defray the cost  
25 of any coverage for breast tomosynthesis outlined in this  
26 paragraph, then the requirement that an insurer cover breast

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

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

11 On and after January 1, 2012, providers participating in a  
12 quality improvement program approved by the Department shall  
13 be reimbursed for screening and diagnostic mammography at the  
14 same rate as the Medicare program's rates, including the  
15 increased reimbursement for digital mammography and, after  
16 January 1, 2023 (the effective date of Public Act 102-1018),  
17 breast tomosynthesis.

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

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

1 cancer treatment quality program.

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

10 Subject to federal approval, the Department shall  
11 establish a rate methodology for mammography at federally  
12 qualified health centers and other encounter-rate clinics.  
13 These clinics or centers may also collaborate with other  
14 hospital-based mammography facilities. By January 1, 2016, the  
15 Department shall report to the General Assembly on the status  
16 of the provision set forth in this paragraph.

17 The Department shall establish a methodology to remind  
18 individuals who are age-appropriate for screening mammography,  
19 but who have not received a mammogram within the previous 18  
20 months, of the importance and benefit of screening  
21 mammography. The Department shall work with experts in breast  
22 cancer outreach and patient navigation to optimize these  
23 reminders and shall establish a methodology for evaluating  
24 their effectiveness and modifying the methodology based on the  
25 evaluation.

26 The Department shall establish a performance goal for

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

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

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

1 in-network covered benefit.

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

13 On or after July 1, 2022, individuals who are otherwise  
14 eligible for medical assistance under this Article shall  
15 receive coverage for perinatal depression screenings for the  
16 12-month period beginning on the last day of their pregnancy.  
17 Medical assistance coverage under this paragraph shall be  
18 conditioned on the use of a screening instrument approved by  
19 the Department.

20 Any medical or health care provider shall immediately  
21 recommend, to any pregnant individual who is being provided  
22 prenatal services and is suspected of having a substance use  
23 disorder as defined in the Substance Use Disorder Act,  
24 referral to a local substance use disorder treatment program  
25 licensed by the Department of Human Services or to a licensed  
26 hospital which provides substance abuse treatment services.

1 The Department of Healthcare and Family Services shall assure  
2 coverage for the cost of treatment of the drug abuse or  
3 addiction for pregnant recipients in accordance with the  
4 Illinois Medicaid Program in conjunction with the Department  
5 of Human Services.

6 All medical providers providing medical assistance to  
7 pregnant individuals under this Code shall receive information  
8 from the Department on the availability of services under any  
9 program providing case management services for addicted  
10 individuals, including information on appropriate referrals  
11 for other social services that may be needed by addicted  
12 individuals in addition to treatment for addiction.

13 The Illinois Department, in cooperation with the  
14 Departments of Human Services (as successor to the Department  
15 of Alcoholism and Substance Abuse) and Public Health, through  
16 a public awareness campaign, may provide information  
17 concerning treatment for alcoholism and drug abuse and  
18 addiction, prenatal health care, and other pertinent programs  
19 directed at reducing the number of drug-affected infants born  
20 to recipients of medical assistance.

21 Neither the Department of Healthcare and Family Services  
22 nor the Department of Human Services shall sanction the  
23 recipient solely on the basis of the recipient's substance  
24 abuse.

25 The Illinois Department shall establish such regulations  
26 governing the dispensing of health services under this Article

1 as it shall deem appropriate. The Department should seek the  
2 advice of formal professional advisory committees appointed by  
3 the Director of the Illinois Department for the purpose of  
4 providing regular advice on policy and administrative matters,  
5 information dissemination and educational activities for  
6 medical and health care providers, and consistency in  
7 procedures to the Illinois Department.

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

18 The sponsor must negotiate formal written contracts with  
19 medical providers for physician services, inpatient and  
20 outpatient hospital care, home health services, treatment for  
21 alcoholism and substance abuse, and other services determined  
22 necessary by the Illinois Department by rule for delivery by  
23 Partnerships. Physician services must include prenatal and  
24 obstetrical care. The Illinois Department shall reimburse  
25 medical services delivered by Partnership providers to clients  
26 in target areas according to provisions of this Article and

1 the Illinois Health Finance Reform Act, except that:

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

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

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

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

23 Nothing in this Section shall limit the free choice of  
24 practitioners, hospitals, and other providers of medical  
25 services by clients. In order to ensure patient freedom of  
26 choice, the Illinois Department shall immediately promulgate

1 all rules and take all other necessary actions so that  
2 provided services may be accessed from therapeutically  
3 certified optometrists to the full extent of the Illinois  
4 Optometric Practice Act of 1987 without discriminating between  
5 service providers.

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

9 The Illinois Department shall require health care  
10 providers to maintain records that document the medical care  
11 and services provided to recipients of Medical Assistance  
12 under this Article. Such records must be retained for a period  
13 of not less than 6 years from the date of service or as  
14 provided by applicable State law, whichever period is longer,  
15 except that if an audit is initiated within the required  
16 retention period then the records must be retained until the  
17 audit is completed and every exception is resolved. The  
18 Illinois Department shall require health care providers to  
19 make available, when authorized by the patient, in writing,  
20 the medical records in a timely fashion to other health care  
21 providers who are treating or serving persons eligible for  
22 Medical Assistance under this Article. All dispensers of  
23 medical services shall be required to maintain and retain  
24 business and professional records sufficient to fully and  
25 accurately document the nature, scope, details and receipt of  
26 the health care provided to persons eligible for medical

1 assistance under this Code, in accordance with regulations  
2 promulgated by the Illinois Department. The rules and  
3 regulations shall require that proof of the receipt of  
4 prescription drugs, dentures, prosthetic devices and  
5 eyeglasses by eligible persons under this Section accompany  
6 each claim for reimbursement submitted by the dispenser of  
7 such medical services. No such claims for reimbursement shall  
8 be approved for payment by the Illinois Department without  
9 such proof of receipt, unless the Illinois Department shall  
10 have put into effect and shall be operating a system of  
11 post-payment audit and review which shall, on a sampling  
12 basis, be deemed adequate by the Illinois Department to assure  
13 that such drugs, dentures, prosthetic devices and eyeglasses  
14 for which payment is being made are actually being received by  
15 eligible recipients. Within 90 days after September 16, 1984  
16 (the effective date of Public Act 83-1439), the Illinois  
17 Department shall establish a current list of acquisition costs  
18 for all prosthetic devices and any other items recognized as  
19 medical equipment and supplies reimbursable under this Article  
20 and shall update such list on a quarterly basis, except that  
21 the acquisition costs of all prescription drugs shall be  
22 updated no less frequently than every 30 days as required by  
23 Section 5-5.12.

24 Notwithstanding any other law to the contrary, the  
25 Illinois Department shall, within 365 days after July 22, 2013  
26 (the effective date of Public Act 98-104), establish

1 procedures to permit skilled care facilities licensed under  
2 the Nursing Home Care Act to submit monthly billing claims for  
3 reimbursement purposes. Following development of these  
4 procedures, the Department shall, by July 1, 2016, test the  
5 viability of the new system and implement any necessary  
6 operational or structural changes to its information  
7 technology platforms in order to allow for the direct  
8 acceptance and payment of nursing home claims.

9 Notwithstanding any other law to the contrary, the  
10 Illinois Department shall, within 365 days after August 15,  
11 2014 (the effective date of Public Act 98-963), establish  
12 procedures to permit ID/DD facilities licensed under the ID/DD  
13 Community Care Act and MC/DD facilities licensed under the  
14 MC/DD Act to submit monthly billing claims for reimbursement  
15 purposes. Following development of these procedures, the  
16 Department shall have an additional 365 days to test the  
17 viability of the new system and to ensure that any necessary  
18 operational or structural changes to its information  
19 technology platforms are implemented.

20 The Illinois Department shall require all dispensers of  
21 medical services, other than an individual practitioner or  
22 group of practitioners, desiring to participate in the Medical  
23 Assistance program established under this Article to disclose  
24 all financial, beneficial, ownership, equity, surety or other  
25 interests in any and all firms, corporations, partnerships,  
26 associations, business enterprises, joint ventures, agencies,

1 institutions or other legal entities providing any form of  
2 health care services in this State under this Article.

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

11 Enrollment of a vendor shall be subject to a provisional  
12 period and shall be conditional for one year. During the  
13 period of conditional enrollment, the Department may terminate  
14 the vendor's eligibility to participate in, or may disenroll  
15 the vendor from, the medical assistance program without cause.  
16 Unless otherwise specified, such termination of eligibility or  
17 disenrollment is not subject to the Department's hearing  
18 process. However, a disenrolled vendor may reapply without  
19 penalty.

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

23 Prior to enrollment and during the conditional enrollment  
24 period in the medical assistance program, all vendors shall be  
25 subject to enhanced oversight, screening, and review based on  
26 the risk of fraud, waste, and abuse that is posed by the

1 category of risk of the vendor. The Illinois Department shall  
2 establish the procedures for oversight, screening, and review,  
3 which may include, but need not be limited to: criminal and  
4 financial background checks; fingerprinting; license,  
5 certification, and authorization verifications; unscheduled or  
6 unannounced site visits; database checks; prepayment audit  
7 reviews; audits; payment caps; payment suspensions; and other  
8 screening as required by federal or State law.

9 The Department shall define or specify the following: (i)  
10 by provider notice, the "category of risk of the vendor" for  
11 each type of vendor, which shall take into account the level of  
12 screening applicable to a particular category of vendor under  
13 federal law and regulations; (ii) by rule or provider notice,  
14 the maximum length of the conditional enrollment period for  
15 each category of risk of the vendor; and (iii) by rule, the  
16 hearing rights, if any, afforded to a vendor in each category  
17 of risk of the vendor that is terminated or disenrolled during  
18 the conditional enrollment period.

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

26 (1) In the case of a provider whose enrollment is in

1 process by the Illinois Department, the 180-day period  
2 shall not begin until the date on the written notice from  
3 the Illinois Department that the provider enrollment is  
4 complete.

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

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

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

16 For claims for services rendered during a period for which  
17 a recipient received retroactive eligibility, claims must be  
18 filed within 180 days after the Department determines the  
19 applicant is eligible. For claims for which the Illinois  
20 Department is not the primary payer, claims must be submitted  
21 to the Illinois Department within 180 days after the final  
22 adjudication by the primary payer.

23 In the case of long term care facilities, within 120  
24 calendar days of receipt by the facility of required  
25 prescreening information, new admissions with associated  
26 admission documents shall be submitted through the Medical

1 Electronic Data Interchange (MEDI) or the Recipient  
2 Eligibility Verification (REV) System or shall be submitted  
3 directly to the Department of Human Services using required  
4 admission forms. Effective September 1, 2014, admission  
5 documents, including all prescreening information, must be  
6 submitted through MEDI or REV. Confirmation numbers assigned  
7 to an accepted transaction shall be retained by a facility to  
8 verify timely submittal. Once an admission transaction has  
9 been completed, all resubmitted claims following prior  
10 rejection are subject to receipt no later than 180 days after  
11 the admission transaction has been completed.

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

16 To the extent consistent with applicable information and  
17 privacy, security, and disclosure laws, State and federal  
18 agencies and departments shall provide the Illinois Department  
19 access to confidential and other information and data  
20 necessary to perform eligibility and payment verifications and  
21 other Illinois Department functions. This includes, but is not  
22 limited to: information pertaining to licensure;  
23 certification; earnings; immigration status; citizenship; wage  
24 reporting; unearned and earned income; pension income;  
25 employment; supplemental security income; social security  
26 numbers; National Provider Identifier (NPI) numbers; the

1 National Practitioner Data Bank (NPDB); program and agency  
2 exclusions; taxpayer identification numbers; tax delinquency;  
3 corporate information; and death records.

4 The Illinois Department shall enter into agreements with  
5 State agencies and departments, and is authorized to enter  
6 into agreements with federal agencies and departments, under  
7 which such agencies and departments shall share data necessary  
8 for medical assistance program integrity functions and  
9 oversight. The Illinois Department shall develop, in  
10 cooperation with other State departments and agencies, and in  
11 compliance with applicable federal laws and regulations,  
12 appropriate and effective methods to share such data. At a  
13 minimum, and to the extent necessary to provide data sharing,  
14 the Illinois Department shall enter into agreements with State  
15 agencies and departments, and is authorized to enter into  
16 agreements with federal agencies and departments, including,  
17 but not limited to: the Secretary of State; the Department of  
18 Revenue; the Department of Public Health; the Department of  
19 Human Services; and the Department of Financial and  
20 Professional Regulation.

21 Beginning in fiscal year 2013, the Illinois Department  
22 shall set forth a request for information to identify the  
23 benefits of a pre-payment, post-adjudication, and post-edit  
24 claims system with the goals of streamlining claims processing  
25 and provider reimbursement, reducing the number of pending or  
26 rejected claims, and helping to ensure a more transparent

1 adjudication process through the utilization of: (i) provider  
2 data verification and provider screening technology; and (ii)  
3 clinical code editing; and (iii) pre-pay, pre-adjudicated, or  
4 post-adjudicated predictive modeling with an integrated case  
5 management system with link analysis. Such a request for  
6 information shall not be considered as a request for proposal  
7 or as an obligation on the part of the Illinois Department to  
8 take any action or acquire any products or services.

9 The Illinois Department shall establish policies,  
10 procedures, standards and criteria by rule for the  
11 acquisition, repair and replacement of orthotic and prosthetic  
12 devices and durable medical equipment. Such rules shall  
13 provide, but not be limited to, the following services: (1)  
14 immediate repair or replacement of such devices by recipients;  
15 and (2) rental, lease, purchase or lease-purchase of durable  
16 medical equipment in a cost-effective manner, taking into  
17 consideration the recipient's medical prognosis, the extent of  
18 the recipient's needs, and the requirements and costs for  
19 maintaining such equipment. Subject to prior approval, such  
20 rules shall enable a recipient to temporarily acquire and use  
21 alternative or substitute devices or equipment pending repairs  
22 or replacements of any device or equipment previously  
23 authorized for such recipient by the Department.  
24 Notwithstanding any provision of Section 5-5f to the contrary,  
25 the Department may, by rule, exempt certain replacement  
26 wheelchair parts from prior approval and, for wheelchairs,

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

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

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

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

15 The Department shall execute, relative to the nursing home  
16 prescreening project, written inter-agency agreements with the  
17 Department of Human Services and the Department on Aging, to  
18 effect the following: (i) intake procedures and common  
19 eligibility criteria for those persons who are receiving  
20 non-institutional services; and (ii) the establishment and  
21 development of non-institutional services in areas of the  
22 State where they are not currently available or are  
23 undeveloped; and (iii) notwithstanding any other provision of  
24 law, subject to federal approval, on and after July 1, 2012, an  
25 increase in the determination of need (DON) scores from 29 to  
26 37 for applicants for institutional and home and

1 community-based long term care; if and only if federal  
2 approval is not granted, the Department may, in conjunction  
3 with other affected agencies, implement utilization controls  
4 or changes in benefit packages to effectuate a similar savings  
5 amount for this population; and (iv) no later than July 1,  
6 2013, minimum level of care eligibility criteria for  
7 institutional and home and community-based long term care; and  
8 (v) no later than October 1, 2013, establish procedures to  
9 permit long term care providers access to eligibility scores  
10 for individuals with an admission date who are seeking or  
11 receiving services from the long term care provider. In order  
12 to select the minimum level of care eligibility criteria, the  
13 Governor shall establish a workgroup that includes affected  
14 agency representatives and stakeholders representing the  
15 institutional and home and community-based long term care  
16 interests. This Section shall not restrict the Department from  
17 implementing lower level of care eligibility criteria for  
18 community-based services in circumstances where federal  
19 approval has been granted.

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

1           The Illinois Department shall report annually to the  
2 General Assembly, no later than the second Friday in April of  
3 1979 and each year thereafter, in regard to:

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

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

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

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

12           The period covered by each report shall be the 3 years  
13 ending on the June 30 prior to the report. The report shall  
14 include suggested legislation for consideration by the General  
15 Assembly. The requirement for reporting to the General  
16 Assembly shall be satisfied by filing copies of the report as  
17 required by Section 3.1 of the General Assembly Organization  
18 Act, and filing such additional copies with the State  
19 Government Report Distribution Center for the General Assembly  
20 as is required under paragraph (t) of Section 7 of the State  
21 Library Act.

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

1 whatever reason, is unauthorized.

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

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

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

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

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

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

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

10 A federally qualified health center, as defined in Section  
11 1905(1)(2)(B) of the federal Social Security Act, shall be  
12 reimbursed by the Department in accordance with the federally  
13 qualified health center's encounter rate for services provided  
14 to medical assistance recipients that are performed by a  
15 dental hygienist, as defined under the Illinois Dental  
16 Practice Act, working under the general supervision of a  
17 dentist and employed by a federally qualified health center.

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

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

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

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

15 Notwithstanding any other provision of this Code, within  
16 12 months after June 2, 2022 (the effective date of Public Act  
17 102-1037) and subject to federal approval, acupuncture  
18 services performed by an acupuncturist licensed under the  
19 Acupuncture Practice Act who is acting within the scope of his  
20 or her license shall be covered under the medical assistance  
21 program. The Department shall apply for any federal waiver or  
22 State Plan amendment, if required, to implement this  
23 paragraph. The Department may adopt any rules, including  
24 standards and criteria, necessary to implement this paragraph.

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

1 reimburse hospitals for costs associated with a newborn  
2 screening test for the presence of metachromatic  
3 leukodystrophy, as required under the Newborn Metabolic  
4 Screening Act, at a rate not less than the fee charged by the  
5 Department of Public Health. Notwithstanding any other  
6 provision of this Code, the medical assistance program shall,  
7 subject to appropriation and federal approval, also reimburse  
8 hospitals for costs associated with all newborn screening  
9 tests added on and after August 9, 2024 (the effective date of  
10 Public Act 103-909) ~~this amendatory Act of the 103rd General~~  
11 ~~Assembly~~ to the Newborn Metabolic Screening Act and required  
12 to be performed under that Act at a rate not less than the fee  
13 charged by the Department of Public Health. The Department  
14 shall seek federal approval before the implementation of the  
15 newborn screening test fees by the Department of Public  
16 Health.

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

25 Notwithstanding any other provision of this Code,  
26 medically necessary reconstructive services that are intended

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

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

11 (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;  
12 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article  
13 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,  
14 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;  
15 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.  
16 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;  
17 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.  
18 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;  
19 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.  
20 1-1-24; 103-593, Article 5, Section 5-5, eff. 6-7-24; 103-593,  
21 Article 90, Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24;  
22 103-808, eff. 1-1-26; 103-909, eff. 8-9-24; 103-1040, eff.  
23 8-9-24; revised 10-10-24.)

1 Section 45-5. The Illinois Public Aid Code is amended by  
2 changing Section 11-4 as follows:

3 (305 ILCS 5/11-4) (from Ch. 23, par. 11-4)

4 Sec. 11-4. Applications; assistance in making  
5 applications. An initial application for public assistance  
6 shall be deemed an application for all such benefits to which  
7 any person may be entitled except to the extent that the  
8 applicant expressly declines in writing to apply for  
9 particular benefits. The redetermination is an annual  
10 redetermination of eligibility of current benefits and is not  
11 an initial application. The Illinois Department shall provide  
12 information in writing about all benefits provided under this  
13 Code to any person seeking public assistance. The Illinois  
14 Department shall also provide information in writing and  
15 orally to all applicants about an election to have financial  
16 aid deposited directly in a recipient's savings account or  
17 checking account or in any electronic benefits account or  
18 accounts as provided in Section 11-3.1, to the extent that  
19 those elections are actually available, including information  
20 on any programs administered by the State Treasurer to  
21 facilitate or encourage the distribution of financial aid by  
22 direct deposit or electronic benefits transfer. The Illinois  
23 Department shall determine the applicant's eligibility for  
24 cash assistance, medical assistance and food stamps unless the  
25 applicant expressly declines in writing to apply for

1 particular benefits. The Illinois Department shall adopt  
2 policies and procedures to facilitate timely changes between  
3 programs that result from changes in categorical eligibility  
4 factors.

5 The County departments, local governmental units and the  
6 Illinois Department shall assist applicants for public  
7 assistance to properly complete their applications. Such  
8 assistance shall include, but not be limited to, assistance in  
9 securing evidence in support of their eligibility.

10 (Source: P.A. 88-232.)

11 ARTICLE 66.

12 Section 66-5. The Illinois Public Aid Code is amended by  
13 changing Section 14-12 as follows:

14 (305 ILCS 5/14-12)

15 Sec. 14-12. Hospital rate reform payment system. The  
16 hospital payment system pursuant to Section 14-11 of this  
17 Article shall be as follows:

18 (a) Inpatient hospital services. Effective ~~for discharges~~  
19 on and after the effective date of this amendatory Act of the  
20 104th General Assembly July 1, 2014, reimbursement for  
21 inpatient general acute care services shall utilize the All  
22 Patient Refined Diagnosis Related Grouping (APR-DRG) software,  
23 ~~version 30,~~ distributed by Solventum<sup>TM</sup> previously known as 3M<sup>TM</sup>

1 Health Information System. Solventum™ shall be the exclusive  
2 provider of this software unless the Department determines  
3 that Solventum™ is unable to meet the required operational or  
4 contractual terms. Only under these circumstances may an  
5 alternative authorized provider of the software be considered.

6 (1) The Department shall establish Medicaid weighting  
7 factors to be used in the reimbursement system established  
8 under this subsection. Initial weighting factors shall be  
9 the weighting factors as published by the authorized  
10 provider of this software ~~3M Health Information System,~~  
11 ~~associated with Version 30.0~~ adjusted for the Illinois  
12 experience.

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

18 (3) In addition to the statewide-standardized amount,  
19 the Department shall develop adjusters to adjust the rate  
20 of reimbursement for critical Medicaid providers or  
21 services for trauma, transplantation services, perinatal  
22 care, and Graduate Medical Education (GME).

23 (4) The Department shall develop add-on payments to  
24 account for exceptionally costly inpatient stays,  
25 consistent with Medicare outlier principles. Outlier fixed  
26 loss thresholds may be updated to control for excessive

1 growth in outlier payments no more frequently than on an  
2 annual basis, but at least once every 4 years. Upon  
3 updating the fixed loss thresholds, the Department shall  
4 be required to update base rates within 12 months.

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

11 (6) Beginning July 1, 2014 and ending on December 31,  
12 2023, in addition to the statewide-standardized amount,  
13 the Department shall develop an adjustor to adjust the  
14 rate of reimbursement for safety-net hospitals defined in  
15 Section 5-5e.1 of this Code excluding pediatric hospitals.

16 (7) Beginning July 1, 2014, in addition to the  
17 statewide-standardized amount, the Department shall  
18 develop an adjustor to adjust the rate of reimbursement  
19 for Illinois freestanding inpatient psychiatric hospitals  
20 that are not designated as children's hospitals by the  
21 Department but are primarily treating patients under the  
22 age of 21.

23 (7.5) (Blank).

24 (8) Beginning July 1, 2018, in addition to the  
25 statewide-standardized amount, the Department shall adjust  
26 the rate of reimbursement for hospitals designated by the

1 Department of Public Health as a Perinatal Level II or II+  
2 center by applying the same adjustor that is applied to  
3 Perinatal and Obstetrical care cases for Perinatal Level  
4 III centers, as of December 31, 2017.

5 (9) Beginning July 1, 2018, in addition to the  
6 statewide-standardized amount, the Department shall apply  
7 the same adjustor that is applied to trauma cases as of  
8 December 31, 2017 to inpatient claims to treat patients  
9 with burns, including, but not limited to, APR-DRGs 841,  
10 842, 843, and 844.

11 (10) Beginning July 1, 2018, the  
12 statewide-standardized amount for inpatient general acute  
13 care services shall be uniformly increased so that base  
14 claims projected reimbursement is increased by an amount  
15 equal to the funds allocated in paragraph (1) of  
16 subsection (b) of Section 5A-12.6, less the amount  
17 allocated under paragraphs (8) and (9) of this subsection  
18 and paragraphs (3) and (4) of subsection (b) multiplied by  
19 40%.

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

23 (b) Outpatient hospital services. Effective on and after  
24 the effective date of this amendatory Act of the 104th General  
25 Assembly, for dates of service on and after July 1, 2014,  
26 reimbursement for outpatient services shall utilize the

1 Enhanced Ambulatory Procedure Grouping (EAPG) software~~7~~  
2 ~~version 3.7~~ distributed by Solventum<sup>TM</sup> previously known as 3M<sup>TM</sup>  
3 Health Information System. Solventum<sup>TM</sup> shall be the exclusive  
4 provider of this software unless the Agency determines that  
5 Solventum<sup>TM</sup> is unable to meet the required operational or  
6 contractual terms. Only under these circumstances may an  
7 alternative authorized provider of the software be considered.

8 (1) The Department shall establish Medicaid weighting  
9 factors to be used in the reimbursement system established  
10 under this subsection. The initial weighting factors shall  
11 be the weighting factors as published by the authorized  
12 provider ~~3M Health Information System, associated with~~  
13 ~~Version 3.7.~~

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

17 (A) The initial statewide standardized amounts,  
18 with the labor portion adjusted by the Calendar Year  
19 2013 Medicare Outpatient Prospective Payment System  
20 wage index with reclassifications, shall be published  
21 by the Department on its website no later than 10  
22 calendar days prior to their effective date.

23 (B) The Department shall establish adjustments to  
24 the statewide-standardized amounts for each Critical  
25 Access Hospital, as designated by the Department of  
26 Public Health in accordance with 42 CFR 485, Subpart

1 F. For outpatient services provided on or before June  
2 30, 2018, the EAPG standardized amounts are determined  
3 separately for each critical access hospital such that  
4 simulated EAPG payments using outpatient base period  
5 paid claim data plus payments under Section 5A-12.4 of  
6 this Code net of the associated tax costs are equal to  
7 the estimated costs of outpatient base period claims  
8 data with a rate year cost inflation factor applied.

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

20 (4) Beginning July 1, 2018, in addition to the  
21 statewide standardized amounts, the Department shall make  
22 an add-on payment for outpatient expensive devices and  
23 drugs. This add-on payment shall at least apply to claim  
24 lines that: (i) are assigned with one of the following  
25 EAPGs: 490, 1001 to 1020, and coded with one of the  
26 following revenue codes: 0274 to 0276, 0278; or (ii) are

1 assigned with one of the following EAPGs: 430 to 441, 443,  
2 444, 460 to 465, 495, 496, 1090. The add-on payment shall  
3 be calculated as follows: the claim line's covered charges  
4 multiplied by the hospital's total acute cost to charge  
5 ratio, less the claim line's EAPG payment plus \$1,000,  
6 multiplied by 0.8.

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

15 (6) Effective for dates of service on or after July 1,  
16 2018, the Department shall establish adjustments to the  
17 statewide-standardized amounts for each Critical Access  
18 Hospital, as designated by the Department of Public Health  
19 in accordance with 42 CFR 485, Subpart F, such that each  
20 Critical Access Hospital's standardized amount for  
21 outpatient services shall be increased by the applicable  
22 uniform percentage determined pursuant to paragraph (5) of  
23 this subsection. It is the intent of the General Assembly  
24 that the adjustments required under this paragraph (6) by  
25 Public Act 100-1181 shall be applied retroactively to  
26 claims for dates of service provided on or after July 1,

1 2018.

2 (7) Effective for dates of service on or after March  
3 8, 2019 (the effective date of Public Act 100-1181), the  
4 Department shall recalculate and implement an updated  
5 statewide-standardized amount for outpatient services  
6 provided by hospitals that are not Critical Access  
7 Hospitals to reflect the applicable uniform percentage  
8 determined pursuant to paragraph (5).

9 (1) Any recalculation to the  
10 statewide-standardized amounts for outpatient services  
11 provided by hospitals that are not Critical Access  
12 Hospitals shall be the amount necessary to achieve the  
13 increase in the statewide-standardized amounts for  
14 outpatient services increased by a uniform percentage,  
15 so that base claims projected reimbursement is  
16 increased by an amount equal to no less than the funds  
17 allocated in paragraph (1) of subsection (b) of  
18 Section 5A-12.6, less the amount allocated under  
19 paragraphs (8) and (9) of subsection (a) and  
20 paragraphs (3) and (4) of this subsection, for all  
21 hospitals that are not Critical Access Hospitals,  
22 multiplied by 46%.

23 (2) It is the intent of the General Assembly that  
24 the recalculations required under this paragraph (7)  
25 by Public Act 100-1181 shall be applied prospectively  
26 to claims for dates of service provided on or after

1 March 8, 2019 (the effective date of Public Act  
2 100-1181) and that no recoupment or repayment by the  
3 Department or an MCO of payments attributable to  
4 recalculation under this paragraph (7), issued to the  
5 hospital for dates of service on or after July 1, 2018  
6 and before March 8, 2019 (the effective date of Public  
7 Act 100-1181), shall be permitted.

8 (8) The Department shall ensure that all necessary  
9 adjustments to the managed care organization capitation  
10 base rates necessitated by the adjustments under  
11 subparagraph (6) or (7) of this subsection are completed  
12 and applied retroactively in accordance with Section  
13 5-30.8 of this Code within 90 days of March 8, 2019 (the  
14 effective date of Public Act 100-1181).

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

21 (b-5) Notwithstanding any other provision of this Section,  
22 beginning with dates of service on and after January 1, 2023,  
23 any general acute care hospital with more than 500 outpatient  
24 psychiatric Medicaid services to persons under 19 years of age  
25 in any calendar year shall be paid the outpatient add-on  
26 payment of no less than \$113.

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

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

21           (1) After the transition period, the Department may  
22 begin incorporating the transitional hospital access pool  
23 into the base rate structure; however, the transitional  
24 hospital access payments in effect on June 30, 2018 shall  
25 continue to be paid, if continued under Section 5A-16.

26           (2) After the transition period, if the Department

1 reduces payments from the transitional hospital access  
2 pool, it shall increase base rates, develop new adjustors,  
3 adjust current adjustors, develop new hospital access  
4 payments based on updated information, or any combination  
5 thereof by an amount equal to the decreases proposed in  
6 the transitional hospital access pool payments, ensuring  
7 that the entire transitional hospital access pool amount  
8 shall continue to be used for hospital payments.

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

16 (1) Phase 1. In State fiscal years 2019 through 2020,  
17 the Department shall allocate funds from the transitional  
18 access hospital pool to create a hospital transformation  
19 pool of at least \$262,906,870 annually and make hospital  
20 transformation payments to hospitals. Subject to Section  
21 5A-16, in State fiscal years 2019 and 2020, an Illinois  
22 hospital that received either a transitional hospital  
23 access payment under subsection (d) or a supplemental  
24 payment under subsection (f) of this Section in State  
25 fiscal year 2018, shall receive a hospital transformation  
26 payment as follows:

1 (A) If the hospital's Rate Year 2017 Medicaid  
2 inpatient utilization rate is equal to or greater than  
3 45%, the hospital transformation payment shall be  
4 equal to 100% of the sum of its transitional hospital  
5 access payment authorized under subsection (d) and any  
6 supplemental payment authorized under subsection (f).

7 (B) If the hospital's Rate Year 2017 Medicaid  
8 inpatient utilization rate is equal to or greater than  
9 25% but less than 45%, the hospital transformation  
10 payment shall be equal to 75% of the sum of its  
11 transitional hospital access payment authorized under  
12 subsection (d) and any supplemental payment authorized  
13 under subsection (f).

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

20 (2) Phase 2.

21 (A) The funding amount from phase one shall be  
22 incorporated into directed payment and pass-through  
23 payment methodologies described in Section 5A-12.7.

24 (B) Because there are communities in Illinois that  
25 experience significant health care disparities due to  
26 systemic racism, as recently emphasized by the

1 COVID-19 pandemic, aggravated by social determinants  
2 of health and a lack of sufficiently allocated health  
3 care ~~healthcare~~ resources, particularly  
4 community-based services, preventive care, obstetric  
5 care, chronic disease management, and specialty care,  
6 the Department shall establish a health care  
7 transformation program that shall be supported by the  
8 transformation funding pool. It is the intention of  
9 the General Assembly that innovative partnerships  
10 funded by the pool must be designed to establish or  
11 improve integrated health care delivery systems that  
12 will provide significant access to the Medicaid and  
13 uninsured populations in their communities, as well as  
14 improve health care equity. It is also the intention  
15 of the General Assembly that partnerships recognize  
16 and address the disparities revealed by the COVID-19  
17 pandemic, as well as the need for post-COVID care.  
18 During State fiscal years 2021 through 2027, the  
19 hospital and health care transformation program shall  
20 be supported by an annual transformation funding pool  
21 of up to \$150,000,000, pending federal matching funds,  
22 to be allocated during the specified fiscal years for  
23 the purpose of facilitating hospital and health care  
24 transformation. No disbursement of moneys for  
25 transformation projects from the transformation  
26 funding pool described under this Section shall be

1 considered an award, a grant, or an expenditure of  
2 grant funds. Funding agreements made in accordance  
3 with the transformation program shall be considered  
4 purchases of care under the Illinois Procurement Code,  
5 and funds shall be expended by the Department in a  
6 manner that maximizes federal funding to expend the  
7 entire allocated amount.

8 The Department shall convene, within 30 days after  
9 March 12, 2021 (the effective date of Public Act  
10 101-655), a workgroup that includes subject matter  
11 experts on health care ~~healthcare~~ disparities and  
12 stakeholders from distressed communities, which could  
13 be a subcommittee of the Medicaid Advisory Committee,  
14 to review and provide recommendations on how  
15 Department policy, including health care  
16 transformation, can improve health disparities and the  
17 impact on communities disproportionately affected by  
18 COVID-19. The workgroup shall consider and make  
19 recommendations on the following issues: a community  
20 safety-net designation of certain hospitals, racial  
21 equity, and a regional partnership to bring additional  
22 specialty services to communities.

23 (C) As provided in paragraph (9) of Section 3 of  
24 the Illinois Health Facilities Planning Act, any  
25 hospital participating in the transformation program  
26 may be excluded from the requirements of the Illinois

1 Health Facilities Planning Act for those projects  
2 related to the hospital's transformation. To be  
3 eligible, the hospital must submit to the Health  
4 Facilities and Services Review Board approval from the  
5 Department that the project is a part of the  
6 hospital's transformation.

7 (D) As provided in subsection (a-20) of Section  
8 32.5 of the Emergency Medical Services (EMS) Systems  
9 Act, a hospital that received hospital transformation  
10 payments under this Section may convert to a  
11 freestanding emergency center. To be eligible for such  
12 a conversion, the hospital must submit to the  
13 Department of Public Health approval from the  
14 Department that the project is a part of the  
15 hospital's transformation.

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

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

23 (ii) the proposal shall be a collaboration  
24 among providers across the care and community  
25 spectrum, including preventative care, primary  
26 care specialty care, hospital services, mental

1 health and substance abuse services, as well as  
2 community-based entities that address the social  
3 determinants of health;

4 (iii) the proposal shall be specifically  
5 designed to improve health care ~~healthcare~~  
6 outcomes and reduce health care ~~healthcare~~  
7 disparities, and improve the coordination,  
8 effectiveness, and efficiency of care delivery;

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

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

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

19 (F) Entities eligible to be funded.

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

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

17           (iii) The Department should target the funding  
18 in the following ways: \$30,000,000 of  
19 transformation funds to projects that are a  
20 collaboration between a safety-net hospital,  
21 particularly community safety-net hospitals, and  
22 other providers and designed to address specific  
23 health care ~~healthcare~~ disparities, \$20,000,000 of  
24 transformation funds to collaborations between  
25 safety-net hospitals and a larger hospital partner  
26 that increases specialty care in distressed

1 communities, \$30,000,000 of transformation funds  
2 to projects that are a collaboration between  
3 hospitals and other providers in distressed areas  
4 of the State designed to address specific health  
5 care ~~healthcare~~ disparities, \$15,000,000 to  
6 collaborations between critical access hospitals  
7 and other providers designed to address specific  
8 health care ~~healthcare~~ disparities, and  
9 \$15,000,000 to cross-provider collaborations  
10 designed to address specific health care  
11 ~~healthcare~~ disparities, and \$5,000,000 to  
12 collaborations that focus on workforce  
13 development.

14 (iv) The Department may allocate up to  
15 \$5,000,000 for planning, racial equity analysis,  
16 or consulting resources for the Department or  
17 entities without the resources to develop a plan  
18 to meet the criteria of this Section. Any contract  
19 for consulting services issued by the Department  
20 under this subparagraph shall comply with the  
21 provisions of Section 5-45 of the State Officials  
22 and Employees Ethics Act. Based on availability of  
23 federal funding, the Department may directly  
24 procure consulting services or provide funding to  
25 the collaboration. The provision of resources  
26 under this subparagraph is not a guarantee that a

1 project will be approved.

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

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

19 (i) A detailed description of how the project  
20 intends to affect the goals outlined in this  
21 subsection, describing new interventions, new  
22 technology, new structures, and other changes to  
23 the health care ~~healthcare~~ delivery system  
24 planned.

25 (ii) A detailed description of the racial and  
26 ethnic makeup of the entities' board and

1 leadership positions and the salaries of the  
2 executive staff of entities in the partnership  
3 that is seeking to obtain funding under this  
4 Section.

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

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

19 (v) A timeline showing the evolution of sites  
20 and specific services of the project over a 5-year  
21 period, including services available to the  
22 community by site.

23 (vi) Clear milestones indicating progress  
24 toward the proposed goals of the proposal as  
25 checkpoints along the way to continue receiving  
26 funding. The Department is authorized to refine

1           these milestones in agreements, and is authorized  
2           to impose reasonable penalties, including  
3           repayment of funds, for substantial lack of  
4           progress.

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

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

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

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

25          (xi) Verifiable project milestones and quality  
26          metrics that will be impacted by transformation.

1           These project milestones and quality metrics must  
2           be identified with improvement targets that must  
3           be met.

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

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

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

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

22          (H) The Department shall evaluate proposals for  
23          compliance with the criteria listed under subparagraph  
24          (G). Proposals meeting all of the criteria may be  
25          eligible for funding with the areas of focus  
26          prioritized as described in item (ii) of subparagraph

1 (F). Based on the funds available, the Department may  
2 negotiate funding agreements with approved applicants  
3 to maximize federal funding. Nothing in this  
4 subsection requires that an approved project be funded  
5 to the level requested. Agreements shall specify the  
6 amount of funding anticipated annually, the  
7 methodology of payments, the limit on the number of  
8 years such funding may be provided, and the milestones  
9 and quality metrics that must be met by the projects in  
10 order to continue to receive funding during each year  
11 of the program. Agreements shall specify the terms and  
12 conditions under which a health care facility that  
13 receives funds under a purchase of care agreement and  
14 closes in violation of the terms of the agreement must  
15 pay an early closure fee no greater than 50% of the  
16 funds it received under the agreement, prior to the  
17 Health Facilities and Services Review Board  
18 considering an application for closure of the  
19 facility. Any project that is funded shall be required  
20 to provide quarterly written progress reports, in a  
21 form prescribed by the Department, and at a minimum  
22 shall include the progress made in achieving any  
23 milestones or metrics or Business Enterprise Program  
24 commitments in its plan. The Department may reduce or  
25 end payments, as set forth in transformation plans, if  
26 milestones or metrics or Business Enterprise Program

1 commitments are not achieved. The Department shall  
2 seek to make payments from the transformation fund in  
3 a manner that is eligible for federal matching funds.

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

17 (3) (Blank).

18 (4) Hospital Transformation Review Committee. There is  
19 created the Hospital Transformation Review Committee. The  
20 Committee shall consist of 14 members. No later than 30  
21 days after March 12, 2018 (the effective date of Public  
22 Act 100-581), the 4 legislative leaders shall each appoint  
23 3 members; the Governor shall appoint the Director of  
24 Healthcare and Family Services, or his or her designee, as  
25 a member; and the Director of Healthcare and Family  
26 Services shall appoint one member. Any vacancy shall be

1 filled by the applicable appointing authority within 15  
2 calendar days. The members of the Committee shall select a  
3 Chair and a Vice-Chair from among its members, provided  
4 that the Chair and Vice-Chair cannot be appointed by the  
5 same appointing authority and must be from different  
6 political parties. The Chair shall have the authority to  
7 establish a meeting schedule and convene meetings of the  
8 Committee, and the Vice-Chair shall have the authority to  
9 convene meetings in the absence of the Chair. The  
10 Committee may establish its own rules with respect to  
11 meeting schedule, notice of meetings, and the disclosure  
12 of documents; however, the Committee shall not have the  
13 power to subpoena individuals or documents and any rules  
14 must be approved by 9 of the 14 members. The Committee  
15 shall perform the functions described in this Section and  
16 advise and consult with the Director in the administration  
17 of this Section. In addition to reviewing and approving  
18 the policies, procedures, and rules for the hospital and  
19 health care transformation program, the Committee shall  
20 consider and make recommendations related to qualifying  
21 criteria and payment methodologies related to safety-net  
22 hospitals and children's hospitals. Members of the  
23 Committee appointed by the legislative leaders shall be  
24 subject to the jurisdiction of the Legislative Ethics  
25 Commission, not the Executive Ethics Commission, and all  
26 requests under the Freedom of Information Act shall be

1 directed to the applicable Freedom of Information officer  
2 for the General Assembly. The Department shall provide  
3 operational support to the Committee as necessary. The  
4 Committee is dissolved on April 1, 2019.

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

12 (f) Continuation of supplemental payments. Any  
13 supplemental payments authorized under 89 Illinois  
14 Administrative Code 148 effective January 1, 2014 and that  
15 continue during the period of July 1, 2014 through December  
16 31, 2014 shall remain in effect as long as the assessment  
17 imposed by Section 5A-2 that is in effect on December 31, 2017  
18 remains in effect.

19 (g) Notwithstanding subsections (a) through (f) of this  
20 Section and notwithstanding the changes authorized under  
21 Section 5-5b.1, any updates to the system shall not result in  
22 any diminishment of the overall effective rates of  
23 reimbursement as of the implementation date of the new system  
24 (July 1, 2014). These updates shall not preclude variations in  
25 any individual component of the system or hospital rate  
26 variations. Nothing in this Section shall prohibit the

1 Department from increasing the rates of reimbursement or  
2 developing payments to ensure access to hospital services.  
3 Nothing in this Section shall be construed to guarantee a  
4 minimum amount of spending in the aggregate or per hospital as  
5 spending may be impacted by factors, including, but not  
6 limited to, the number of individuals in the medical  
7 assistance program and the severity of illness of the  
8 individuals.

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

14 (i) Except for subsections (g) and (h) of this Section,  
15 the Department shall, pursuant to subsection (c) of Section  
16 5-40 of the Illinois Administrative Procedure Act, provide for  
17 presentation at the June 2014 hearing of the Joint Committee  
18 on Administrative Rules (JCAR) additional written notice to  
19 JCAR of the following rules in order to commence the second  
20 notice period for the following rules: rules published in the  
21 Illinois Register, rule dated February 21, 2014 at 38 Ill.  
22 Reg. 4559 (Medical Payment), 4628 (Specialized Health Care  
23 Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic  
24 Related Grouping (DRG) Prospective Payment System (PPS)), and  
25 4977 (Hospital Reimbursement Changes), and published in the  
26 Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499

1 (Specialized Health Care Delivery Systems) and 6505 (Hospital  
2 Services).

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

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

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

16 (Source: P.A. 102-682, eff. 12-10-21; 102-1037, eff. 6-2-22;  
17 103-102, eff. 6-16-23; 103-154, eff. 6-30-23; revised  
18 10-16-24.)

19 ARTICLE 67.

20 Section 67-5. The Illinois Public Aid Code is amended by  
21 adding Section 10-3.5 as follows:

22 (305 ILCS 5/10-3.5 new)

23 Sec. 10-3.5. Connecting parents to available resources.

1 Beginning July 1, 2025, subject to appropriation and the  
2 availability of federal matching funds for the costs to the  
3 Department of Healthcare and Family Services for the  
4 implementation of this Section, the Illinois Department shall  
5 enter into agreements with other State agencies, including,  
6 but not limited to, the Department of Employment Security and  
7 the Department of Central Management Services, to implement a  
8 program designed to connect available resources to  
9 noncustodial parents whose families are receiving child  
10 support enforcement services; who have a child support order  
11 or are cooperating to establish a child support order; and who  
12 are unemployed or underemployed or at risk of not being able to  
13 comply with their support order. The program shall seek to  
14 connect parents with resources providing: job search  
15 assistance; job readiness training; job development and job  
16 placement services; skills assessments to facilitate job  
17 placement; job retention services; work supports; and  
18 occupational training and other skills training related to  
19 employment. The opportunities provided to program participants  
20 shall include opportunities offered by employers located in  
21 the State, including, but not limited to, State employment.

22 ARTICLE 68.

23 Section 68-3. The Illinois Administrative Procedure Act is  
24 amended by adding Section 5-45.65 as follows:

1 (5 ILCS 100/5-45.65 new)

2 Sec. 5-45.65. Emergency rulemaking; Medicaid managed care  
3 organization practices. To provide for the expeditious and  
4 timely implementation of changes made by this amendatory Act  
5 of the 104th General Assembly to subsection (g-13) of Section  
6 5-30.1 of the Illinois Public Aid Code, emergency rules  
7 implementing the changes made by this amendatory Act of the  
8 104th General Assembly to subsection (g-13) of Section 5-30.1  
9 of the Illinois Public Aid Code may be adopted in accordance  
10 with Section 5-45 by the Department of Healthcare and Family  
11 Services. The adoption of emergency rules authorized by  
12 Section 5-45 and this Section is deemed to be necessary for the  
13 public interest, safety, and welfare.

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

16 Section 68-5. The Illinois Public Aid Code is amended by  
17 changing Sections 5-30.1 and 5-30.18 as follows:

18 (305 ILCS 5/5-30.1)

19 Sec. 5-30.1. Managed care protections.

20 (a) As used in this Section:

21 "Managed care organization" or "MCO" means any entity  
22 which contracts with the Department to provide services where  
23 payment for medical services is made on a capitated basis.

1 "Emergency services" means health care items and services,  
2 including inpatient and outpatient hospital services,  
3 furnished or required to evaluate and stabilize an emergency  
4 medical condition. "Emergency services" include inpatient  
5 stabilization services furnished during the inpatient  
6 stabilization period. "Emergency services" do not include  
7 post-stabilization medical services.

8 "Emergency medical condition" means a medical condition  
9 manifesting itself by acute symptoms of sufficient severity,  
10 regardless of the final diagnosis given, such that a prudent  
11 layperson, who possesses an average knowledge of health and  
12 medicine, could reasonably expect the absence of immediate  
13 medical attention to result in:

14 (1) placing the health of the individual (or, with  
15 respect to a pregnant woman, the health of the woman or her  
16 unborn child) in serious jeopardy;

17 (2) serious impairment to bodily functions;

18 (3) serious dysfunction of any bodily organ or part;

19 (4) inadequately controlled pain; or

20 (5) with respect to a pregnant woman who is having  
21 contractions:

22 (A) inadequate time to complete a safe transfer to  
23 another hospital before delivery; or

24 (B) a transfer to another hospital may pose a  
25 threat to the health or safety of the woman or unborn  
26 child.

1 "Emergency medical screening examination" means a medical  
2 screening examination and evaluation by a physician licensed  
3 to practice medicine in all its branches or, to the extent  
4 permitted by applicable laws, by other appropriately licensed  
5 personnel under the supervision of or in collaboration with a  
6 physician licensed to practice medicine in all its branches to  
7 determine whether the need for emergency services exists.

8 "Health care services" mean any medical or behavioral  
9 health services covered under the medical assistance program  
10 that are subject to review under a service authorization  
11 program.

12 "Inpatient stabilization period" means the initial 72  
13 hours of inpatient stabilization services, beginning from the  
14 date and time of the order for inpatient admission to the  
15 hospital.

16 "Inpatient stabilization services" mean emergency services  
17 furnished in the inpatient setting at a hospital pursuant to  
18 an order for inpatient admission by a physician or other  
19 qualified practitioner who has admitting privileges at the  
20 hospital, as permitted by State law, to stabilize an emergency  
21 medical condition following an emergency medical screening  
22 examination.

23 "Post-stabilization medical services" means health care  
24 services provided to an enrollee that are furnished in a  
25 hospital by a provider that is qualified to furnish such  
26 services and determined to be medically necessary by the

1 provider and directly related to the emergency medical  
2 condition following stabilization.

3 "Provider" means a facility or individual who is actively  
4 enrolled in the medical assistance program and licensed or  
5 otherwise authorized to order, prescribe, refer, or render  
6 health care services in this State.

7 "Service authorization determination" means a decision  
8 made by a service authorization program in advance of,  
9 concurrent to, or after the provision of a health care service  
10 to approve, change the level of care, partially deny, deny, or  
11 otherwise limit coverage and reimbursement for a health care  
12 service upon review of a service authorization request.

13 "Service authorization program" means any utilization  
14 review, utilization management, peer review, quality review,  
15 or other medical management activity conducted by an MCO, or  
16 its contracted utilization review organization, including, but  
17 not limited to, prior authorization, prior approval,  
18 pre-certification, concurrent review, retrospective review, or  
19 certification of admission, of health care services provided  
20 in the inpatient or outpatient hospital setting.

21 "Service authorization request" means a request by a  
22 provider to a service authorization program to determine  
23 whether a health care service meets the reimbursement  
24 eligibility requirements for medically necessary, clinically  
25 appropriate care, resulting in the issuance of a service  
26 authorization determination.

1 "Utilization review organization" or "URO" means an MCO's  
2 utilization review department or a peer review organization or  
3 quality improvement organization that contracts with an MCO to  
4 administer a service authorization program and make service  
5 authorization determinations.

6 (b) As provided by Section 5-16.12, managed care  
7 organizations are subject to the provisions of the Managed  
8 Care Reform and Patient Rights Act.

9 (c) An MCO shall pay any provider of emergency services,  
10 including for inpatient stabilization services provided during  
11 the inpatient stabilization period, that does not have in  
12 effect a contract with the contracted Medicaid MCO. The  
13 default rate of reimbursement shall be the rate paid under  
14 Illinois Medicaid fee-for-service program methodology,  
15 including all policy adjusters, including but not limited to  
16 Medicaid High Volume Adjustments, Medicaid Percentage  
17 Adjustments, Outpatient High Volume Adjustments, and all  
18 outlier add-on adjustments to the extent such adjustments are  
19 incorporated in the development of the applicable MCO  
20 capitated rates.

21 (d) (Blank).

22 (e) Notwithstanding any other provision of law, the  
23 following requirements apply to MCOs in determining payment  
24 for all emergency services, including inpatient stabilization  
25 services provided during the inpatient stabilization period:

26 (1) The MCO shall not impose any service authorization

1 program requirements for emergency services, including,  
2 but not limited to, prior authorization, prior approval,  
3 pre-certification, certification of admission, concurrent  
4 review, or retrospective review.

5 (A) Notification period: Hospitals shall notify  
6 the enrollee's Medicaid MCO within 48 hours of the  
7 date and time the order for inpatient admission is  
8 written. Notification shall be limited to advising the  
9 MCO that the patient has been admitted to a hospital  
10 inpatient level of care.

11 (B) If the admitting hospital complies with the  
12 notification provisions of subparagraph (A), the  
13 Medicaid MCO may not initiate concurrent review before  
14 the end of the inpatient stabilization period. If the  
15 admitting hospital does not comply with the  
16 notification requirements in subparagraph (A), the  
17 Medicaid MCO may initiate concurrent review for the  
18 continuation of the stay beginning at the end of the  
19 48-hour notification period.

20 (C) Coverage for services provided during the  
21 48-hour notification period may not be retrospectively  
22 denied.

23 (2) The MCO shall cover emergency services provided to  
24 enrollees who are temporarily away from their residence  
25 and outside the contracting area to the extent that the  
26 enrollees would be entitled to the emergency services if

1           they still were within the contracting area.

2           (3) The MCO shall have no obligation to cover  
3 emergency services provided on an emergency basis that are  
4 not covered services under the contract between the MCO  
5 and the Department.

6           (4) The MCO shall not condition coverage for emergency  
7 services on the treating provider notifying the MCO of the  
8 enrollee's emergency medical screening examination and  
9 treatment within 10 days after presentation for emergency  
10 services.

11           (5) The determination of the attending emergency  
12 physician, or the practitioner responsible for the  
13 enrollee's care at the hospital, of whether an enrollee  
14 requires inpatient stabilization services, can be  
15 stabilized in the outpatient setting, or is sufficiently  
16 stabilized for discharge or transfer to another setting,  
17 shall be binding on the MCO. The MCO shall cover and  
18 reimburse providers for emergency services as billed by  
19 the provider for all enrollees whether the emergency  
20 services are provided by an affiliated or non-affiliated  
21 provider, except in cases of fraud. The MCO shall  
22 reimburse inpatient stabilization services provided during  
23 the inpatient stabilization period and billed as inpatient  
24 level of care based on the appropriate inpatient  
25 reimbursement methodology.

26           (6) The MCO's financial responsibility for

1 post-stabilization medical services it has not  
2 pre-approved ends when:

3 (A) a plan physician with privileges at the  
4 treating hospital assumes responsibility for the  
5 enrollee's care;

6 (B) a plan physician assumes responsibility for  
7 the enrollee's care through transfer;

8 (C) a contracting entity representative and the  
9 treating physician reach an agreement concerning the  
10 enrollee's care; or

11 (D) the enrollee is discharged.

12 (e-5) An MCO shall pay for all post-stabilization medical  
13 services as a covered service in any of the following  
14 situations:

15 (1) the MCO or its URO authorized such services;

16 (2) such services were administered to maintain the  
17 enrollee's stabilized condition within one hour after a  
18 request to the MCO for authorization of further  
19 post-stabilization services;

20 (3) the MCO or its URO did not respond to a request to  
21 authorize such services within one hour;

22 (4) the MCO or its URO could not be contacted; or

23 (5) the MCO or its URO and the treating provider, if  
24 the treating provider is a non-affiliated provider, could  
25 not reach an agreement concerning the enrollee's care and  
26 an affiliated provider was unavailable for a consultation,

1 in which case the MCO must pay for such services rendered  
2 by the treating non-affiliated provider until an  
3 affiliated provider was reached and either concurred with  
4 the treating non-affiliated provider's plan of care or  
5 assumed responsibility for the enrollee's care. Such  
6 payment shall be made at the default rate of reimbursement  
7 paid under the State's Medicaid fee-for-service program  
8 methodology, including all policy adjusters, including,  
9 but not limited to, Medicaid High Volume Adjustments,  
10 Medicaid Percentage Adjustments, Outpatient High Volume  
11 Adjustments, and all outlier add-on adjustments to the  
12 extent that such adjustments are incorporated in the  
13 development of the applicable MCO capitated rates.

14 (f) Network adequacy and transparency.

15 (1) The Department shall:

16 (A) ensure that an adequate provider network is in  
17 place, taking into consideration health professional  
18 shortage areas and medically underserved areas;

19 (B) publicly release an explanation of its process  
20 for analyzing network adequacy;

21 (C) periodically ensure that an MCO continues to  
22 have an adequate network in place;

23 (D) require MCOs, including Medicaid Managed Care  
24 Entities as defined in Section 5-30.2, to meet  
25 provider directory requirements under Section 5-30.3;

26 (E) require MCOs to ensure that any

1 Medicaid-certified provider under contract with an MCO  
2 and previously submitted on a roster on the date of  
3 service is paid for any medically necessary,  
4 Medicaid-covered, and authorized service rendered to  
5 any of the MCO's enrollees, regardless of inclusion on  
6 the MCO's published and publicly available directory  
7 of available providers; and

8 (F) require MCOs, including Medicaid Managed Care  
9 Entities as defined in Section 5-30.2, to meet each of  
10 the requirements under subsection (d-5) of Section 10  
11 of the Network Adequacy and Transparency Act; with  
12 necessary exceptions to the MCO's network to ensure  
13 that admission and treatment with a provider or at a  
14 treatment facility in accordance with the network  
15 adequacy standards in paragraph (3) of subsection  
16 (d-5) of Section 10 of the Network Adequacy and  
17 Transparency Act is limited to providers or facilities  
18 that are Medicaid certified.

19 (2) Each MCO shall confirm its receipt of information  
20 submitted specific to physician or dentist additions or  
21 physician or dentist deletions from the MCO's provider  
22 network within 3 days after receiving all required  
23 information from contracted physicians or dentists, and  
24 electronic physician and dental directories must be  
25 updated consistent with current rules as published by the  
26 Centers for Medicare and Medicaid Services or its

1 successor agency.

2 (g) Timely payment of claims.

3 (1) The MCO shall pay a claim within 30 days of  
4 receiving a claim that contains all the essential  
5 information needed to adjudicate the claim.

6 (2) The MCO shall notify the billing party of its  
7 inability to adjudicate a claim within 30 days of  
8 receiving that claim.

9 (3) The MCO shall pay a penalty that is at least equal  
10 to the timely payment interest penalty imposed under  
11 Section 368a of the Illinois Insurance Code for any claims  
12 not timely paid.

13 (A) When an MCO is required to pay a timely payment  
14 interest penalty to a provider, the MCO must calculate  
15 and pay the timely payment interest penalty that is  
16 due to the provider within 30 days after the payment of  
17 the claim. In no event shall a provider be required to  
18 request or apply for payment of any owed timely  
19 payment interest penalties.

20 (B) Such payments shall be reported separately  
21 from the claim payment for services rendered to the  
22 MCO's enrollee and clearly identified as interest  
23 payments.

24 (4) (A) The Department shall require MCOs to expedite  
25 payments to providers identified on the Department's  
26 expedited provider list, determined in accordance with 89

1 Ill. Adm. Code 140.71(b), on a schedule at least as  
2 frequently as the providers are paid under the  
3 Department's fee-for-service expedited provider schedule.

4 (B) Compliance with the expedited provider requirement  
5 may be satisfied by an MCO through the use of a Periodic  
6 Interim Payment (PIP) program that has been mutually  
7 agreed to and documented between the MCO and the provider,  
8 if the PIP program ensures that any expedited provider  
9 receives regular and periodic payments based on prior  
10 period payment experience from that MCO. Total payments  
11 under the PIP program may be reconciled against future PIP  
12 payments on a schedule mutually agreed to between the MCO  
13 and the provider.

14 (C) The Department shall share at least monthly its  
15 expedited provider list and the frequency with which it  
16 pays providers on the expedited list.

17 (g-5) Recognizing that the rapid transformation of the  
18 Illinois Medicaid program may have unintended operational  
19 challenges for both payers and providers:

20 (1) in no instance shall a medically necessary covered  
21 service rendered in good faith, based upon eligibility  
22 information documented by the provider, be denied coverage  
23 or diminished in payment amount if the eligibility or  
24 coverage information available at the time the service was  
25 rendered is later found to be inaccurate in the assignment  
26 of coverage responsibility between MCOs or the

1 fee-for-service system, except for instances when an  
2 individual is deemed to have not been eligible for  
3 coverage under the Illinois Medicaid program; and

4 (2) the Department shall, by December 31, 2016, adopt  
5 rules establishing policies that shall be included in the  
6 Medicaid managed care policy and procedures manual  
7 addressing payment resolutions in situations in which a  
8 provider renders services based upon information obtained  
9 after verifying a patient's eligibility and coverage plan  
10 through either the Department's current enrollment system  
11 or a system operated by the coverage plan identified by  
12 the patient presenting for services:

13 (A) such medically necessary covered services  
14 shall be considered rendered in good faith;

15 (B) such policies and procedures shall be  
16 developed in consultation with industry  
17 representatives of the Medicaid managed care health  
18 plans and representatives of provider associations  
19 representing the majority of providers within the  
20 identified provider industry; and

21 (C) such rules shall be published for a review and  
22 comment period of no less than 30 days on the  
23 Department's website with final rules remaining  
24 available on the Department's website.

25 The rules on payment resolutions shall include, but  
26 not be limited to:

- 1 (A) the extension of the timely filing period;
- 2 (B) retroactive prior authorizations; and
- 3 (C) guaranteed minimum payment rate of no less
- 4 than the current, as of the date of service,
- 5 fee-for-service rate, plus all applicable add-ons,
- 6 when the resulting service relationship is out of
- 7 network.

8 The rules shall be applicable for both MCO coverage

9 and fee-for-service coverage.

10 If the fee-for-service system is ultimately determined to

11 have been responsible for coverage on the date of service, the

12 Department shall provide for an extended period for claims

13 submission outside the standard timely filing requirements.

14 (g-6) MCO Performance Metrics Report.

15 (1) The Department shall publish, on at least a

16 quarterly basis, each MCO's operational performance,

17 including, but not limited to, the following categories of

18 metrics:

- 19 (A) claims payment, including timeliness and
- 20 accuracy;
- 21 (B) prior authorizations;
- 22 (C) grievance and appeals;
- 23 (D) utilization statistics;
- 24 (E) provider disputes;
- 25 (F) provider credentialing; and
- 26 (G) member and provider customer service.

1           (2) The Department shall ensure that the metrics  
2 report is accessible to providers online by January 1,  
3 2017.

4           (3) The metrics shall be developed in consultation  
5 with industry representatives of the Medicaid managed care  
6 health plans and representatives of associations  
7 representing the majority of providers within the  
8 identified industry.

9           (4) Metrics shall be defined and incorporated into the  
10 applicable Managed Care Policy Manual issued by the  
11 Department.

12           (g-7) MCO claims processing and performance analysis. In  
13 order to monitor MCO payments to hospital providers, pursuant  
14 to Public Act 100-580, the Department shall post an analysis  
15 of MCO claims processing and payment performance on its  
16 website every 6 months. Such analysis shall include a review  
17 and evaluation of a representative sample of hospital claims  
18 that are rejected and denied for clean and unclean claims and  
19 the top 5 reasons for such actions and timeliness of claims  
20 adjudication, which identifies the percentage of claims  
21 adjudicated within 30, 60, 90, and over 90 days, and the dollar  
22 amounts associated with those claims.

23           (g-8) Dispute resolution process. The Department shall  
24 maintain a provider complaint portal through which a provider  
25 can submit to the Department unresolved disputes with an MCO.  
26 An unresolved dispute means an MCO's decision that denies in

1 whole or in part a claim for reimbursement to a provider for  
2 health care services rendered by the provider to an enrollee  
3 of the MCO with which the provider disagrees. Disputes shall  
4 not be submitted to the portal until the provider has availed  
5 itself of the MCO's internal dispute resolution process.  
6 Disputes that are submitted to the MCO internal dispute  
7 resolution process may be submitted to the Department of  
8 Healthcare and Family Services' complaint portal no sooner  
9 than 30 days after submitting to the MCO's internal process  
10 and not later than 30 days after the unsatisfactory resolution  
11 of the internal MCO process or 60 days after submitting the  
12 dispute to the MCO internal process. Multiple claim disputes  
13 involving the same MCO may be submitted in one complaint,  
14 regardless of whether the claims are for different enrollees,  
15 when the specific reason for non-payment of the claims  
16 involves a common question of fact or policy. Within 10  
17 business days of receipt of a complaint, the Department shall  
18 present such disputes to the appropriate MCO, which shall then  
19 have 30 days to issue its written proposal to resolve the  
20 dispute. The Department may grant one 30-day extension of this  
21 time frame to one of the parties to resolve the dispute. If the  
22 dispute remains unresolved at the end of this time frame or the  
23 provider is not satisfied with the MCO's written proposal to  
24 resolve the dispute, the provider may, within 30 days, request  
25 the Department to review the dispute and make a final  
26 determination. Within 30 days of the request for Department

1 review of the dispute, both the provider and the MCO shall  
2 present all relevant information to the Department for  
3 resolution and make individuals with knowledge of the issues  
4 available to the Department for further inquiry if needed.  
5 Within 30 days of receiving the relevant information on the  
6 dispute, or the lapse of the period for submitting such  
7 information, the Department shall issue a written decision on  
8 the dispute based on contractual terms between the provider  
9 and the MCO, contractual terms between the MCO and the  
10 Department of Healthcare and Family Services and applicable  
11 Medicaid policy. The decision of the Department shall be  
12 final. By January 1, 2020, the Department shall establish by  
13 rule further details of this dispute resolution process.  
14 Disputes between MCOs and providers presented to the  
15 Department for resolution are not contested cases, as defined  
16 in Section 1-30 of the Illinois Administrative Procedure Act,  
17 conferring any right to an administrative hearing.

18 (g-9) (1) The Department shall publish annually on its  
19 website a report on the calculation of each managed care  
20 organization's medical loss ratio showing the following:

21 (A) Premium revenue, with appropriate adjustments.

22 (B) Benefit expense, setting forth the aggregate  
23 amount spent for the following:

24 (i) Direct paid claims.

25 (ii) Subcapitation payments.

26 (iii) Other claim payments.

1 (iv) Direct reserves.

2 (v) Gross recoveries.

3 (vi) Expenses for activities that improve health  
4 care quality as allowed by the Department.

5 (2) The medical loss ratio shall be calculated consistent  
6 with federal law and regulation following a claims runout  
7 period determined by the Department.

8 (g-10) (1) "Liability effective date" means the date on  
9 which an MCO becomes responsible for payment for medically  
10 necessary and covered services rendered by a provider to one  
11 of its enrollees in accordance with the contract terms between  
12 the MCO and the provider. The liability effective date shall  
13 be the later of:

14 (A) The execution date of a network participation  
15 contract agreement.

16 (B) The date the provider or its representative  
17 submits to the MCO the complete and accurate standardized  
18 roster form for the provider in the format approved by the  
19 Department.

20 (C) The provider effective date contained within the  
21 Department's provider enrollment subsystem within the  
22 Illinois Medicaid Program Advanced Cloud Technology  
23 (IMPACT) System.

24 (2) The standardized roster form may be submitted to the  
25 MCO at the same time that the provider submits an enrollment  
26 application to the Department through IMPACT.

1           (3) By October 1, 2019, the Department shall require all  
2 MCOs to update their provider directory with information for  
3 new practitioners of existing contracted providers within 30  
4 days of receipt of a complete and accurate standardized roster  
5 template in the format approved by the Department provided  
6 that the provider is effective in the Department's provider  
7 enrollment subsystem within the IMPACT system. Such provider  
8 directory shall be readily accessible for purposes of  
9 selecting an approved health care provider and comply with all  
10 other federal and State requirements.

11           (g-11) The Department shall work with relevant  
12 stakeholders on the development of operational guidelines to  
13 enhance and improve operational performance of Illinois'  
14 Medicaid managed care program, including, but not limited to,  
15 improving provider billing practices, reducing claim  
16 rejections and inappropriate payment denials, and  
17 standardizing processes, procedures, definitions, and response  
18 timelines, with the goal of reducing provider and MCO  
19 administrative burdens and conflict. The Department shall  
20 include a report on the progress of these program improvements  
21 and other topics in its Fiscal Year 2020 annual report to the  
22 General Assembly.

23           (g-12) Notwithstanding any other provision of law, if the  
24 Department or an MCO requires submission of a claim for  
25 payment in a non-electronic format, a provider shall always be  
26 afforded a period of no less than 90 business days, as a

1 correction period, following any notification of rejection by  
2 either the Department or the MCO to correct errors or  
3 omissions in the original submission.

4 Under no circumstances, either by an MCO or under the  
5 State's fee-for-service system, shall a provider be denied  
6 payment for failure to comply with any timely submission  
7 requirements under this Code or under any existing contract,  
8 unless the non-electronic format claim submission occurs after  
9 the initial 180 days following the latest date of service on  
10 the claim, or after the 90 business days correction period  
11 following notification to the provider of rejection or denial  
12 of payment.

13 (g-13) Utilization Review Standardization and  
14 Transparency.

15 (1) To ensure greater standardization and transparency  
16 related to service authorization determinations, for all  
17 individuals covered under the medical assistance program,  
18 including both the fee-for-service and managed care  
19 programs, the Department shall, in consultation with the  
20 MCOs, a statewide association representing the MCOs, a  
21 statewide association representing the majority of  
22 Illinois hospitals, a statewide association representing  
23 physicians, or any other interested parties deemed  
24 appropriate by the Department, adopt administrative rules  
25 consistent with this subsection, in accordance with the  
26 Illinois Administrative Procedure Act.

1           (2) No later than ~~Prior to~~ July 1, 2025, the  
2 Department shall in accordance with the Illinois  
3 Administrative Procedure Act file emergency rules, and  
4 adopt permanent rules no later than October 1, 2025, adopt  
5 ~~rules~~ which govern MCO practices for dates of services on  
6 and after July 1, 2025, as follows:

7           (A) guidelines related to the publication of MCO  
8 authorization policies;

9           (B) procedures that, due to medical complexity,  
10 must be reimbursed under the applicable inpatient  
11 methodology, when provided in the inpatient setting  
12 and billed as an inpatient service;

13           (C) standardization of administrative forms used  
14 in the member appeal process;

15           (D) limitations on second or subsequent medical  
16 necessity review of a health care service already  
17 authorized by the MCO or URO under a service  
18 authorization program;

19           (E) standardization of peer-to-peer processes and  
20 timelines;

21           (F) defined criteria for urgent and standard  
22 post-acute care and long-term acute care service  
23 authorization requests; and

24           (G) standardized criteria for service  
25 authorization programs for authorization of admission  
26 to a long-term acute care hospital.

1           (3) The Department shall expand the scope of the  
2           quality and compliance audits conducted by its contracted  
3           external quality review organization to include, but not  
4           be limited to:

5                   (A) an analysis of the Medicaid MCO's compliance  
6                   with nationally recognized clinical decision  
7                   guidelines;

8                   (B) an analysis that compares and contrasts the  
9                   Medicaid MCO's service authorization determination  
10                  outcomes to the outcomes of each other MCO plan and the  
11                  State's fee-for-service program model to evaluate  
12                  whether service authorization determinations are being  
13                  made consistently by all Medicaid MCOs to ensure that  
14                  all individuals are being treated in accordance with  
15                  equitable standards of care;

16                  (C) an analysis, for each Medicaid MCO, of the  
17                  number of service authorization requests, including  
18                  requests for concurrent review and certification of  
19                  admissions, received, initially denied, overturned  
20                  through any post-denial process including, but not  
21                  limited to, enrollee or provider appeal, peer-to-peer  
22                  review, or the provider dispute resolution process,  
23                  denied but approved for a lower or different level of  
24                  care, and the number denied on final determination;  
25                  and

26                  (D) provide a written report to the General

1 Assembly, detailing the items listed in this  
2 subsection and any other metrics deemed necessary by  
3 the Department, by the second April, following June 7,  
4 2024 (the effective date of Public Act 103-593) ~~this~~  
5 ~~amendatory Act of the 103rd General Assembly~~, and each  
6 April thereafter. The Department shall make this  
7 report available within 30 days of delivery to the  
8 General Assembly, on its public facing website.

9 (h) The Department shall not expand mandatory MCO  
10 enrollment into new counties beyond those counties already  
11 designated by the Department as of June 1, 2014 for the  
12 individuals whose eligibility for medical assistance is not  
13 the seniors or people with disabilities population until the  
14 Department provides an opportunity for accountable care  
15 entities and MCOs to participate in such newly designated  
16 counties.

17 (h-5) Leading indicator data sharing. By January 1, 2024,  
18 the Department shall obtain input from the Department of Human  
19 Services, the Department of Juvenile Justice, the Department  
20 of Children and Family Services, the State Board of Education,  
21 managed care organizations, providers, and clinical experts to  
22 identify and analyze key indicators and data elements that can  
23 be used in an analysis of lead indicators from assessments and  
24 data sets available to the Department that can be shared with  
25 managed care organizations and similar care coordination  
26 entities contracted with the Department as leading indicators

1 for elevated behavioral health crisis risk for children,  
2 including data sets such as the Illinois Medicaid  
3 Comprehensive Assessment of Needs and Strengths (IM-CANS),  
4 calls made to the State's Crisis and Referral Entry Services  
5 (CARES) hotline, health services information from Health and  
6 Human Services Innovators, or other data sets that may include  
7 key indicators. The workgroup shall complete its  
8 recommendations for leading indicator data elements on or  
9 before September 1, 2024. To the extent permitted by State and  
10 federal law, the identified leading indicators shall be shared  
11 with managed care organizations and similar care coordination  
12 entities contracted with the Department on or before December  
13 1, 2024 for the purpose of improving care coordination with  
14 the early detection of elevated risk. Leading indicators shall  
15 be reassessed annually with stakeholder input. The Department  
16 shall implement guidance to managed care organizations and  
17 similar care coordination entities contracted with the  
18 Department, so that the managed care organizations and care  
19 coordination entities respond to lead indicators with services  
20 and interventions that are designed to help stabilize the  
21 child.

22 (i) The requirements of this Section apply to contracts  
23 with accountable care entities and MCOs entered into, amended,  
24 or renewed after June 16, 2014 (the effective date of Public  
25 Act 98-651).

26 (j) Health care information released to managed care

1 organizations. A health care provider shall release to a  
2 Medicaid managed care organization, upon request, and subject  
3 to the Health Insurance Portability and Accountability Act of  
4 1996 and any other law applicable to the release of health  
5 information, the health care information of the MCO's  
6 enrollee, if the enrollee has completed and signed a general  
7 release form that grants to the health care provider  
8 permission to release the recipient's health care information  
9 to the recipient's insurance carrier.

10 (k) The Department of Healthcare and Family Services,  
11 managed care organizations, a statewide organization  
12 representing hospitals, and a statewide organization  
13 representing safety-net hospitals shall explore ways to  
14 support billing departments in safety-net hospitals.

15 (l) The requirements of this Section added by Public Act  
16 102-4 shall apply to services provided on or after the first  
17 day of the month that begins 60 days after April 27, 2021 (the  
18 effective date of Public Act 102-4).

19 (m) Except where otherwise expressly specified, the  
20 requirements of this Section added by Public Act 103-593 ~~this~~  
21 ~~amendatory Act of the 103rd General Assembly~~ shall apply to  
22 services provided on and after July 1, 2026 ~~on or after July 1,~~  
23 ~~2025.~~

24 (Source: P.A. 102-4, eff. 4-27-21; 102-43, eff. 7-6-21;  
25 102-144, eff. 1-1-22; 102-454, eff. 8-20-21; 102-813, eff.  
26 5-13-22; 103-546, eff. 8-11-23; 103-593, eff. 6-7-24; 103-885,

1 eff. 8-9-24; revised 10-7-24.)

2 (305 ILCS 5/5-30.18)

3 (Section scheduled to be repealed on December 31, 2030)

4 Sec. 5-30.18. Service authorization program performance.

5 (a) Definitions. As used in this Section:

6 "Gold Card provider" means a provider identified by each  
7 Medicaid Managed Care Organization (MCO) as qualified under  
8 the guidelines outlined by the Department in accordance with  
9 subsection (c) and thereby granted a service authorization  
10 exemption when ordering a health care service.

11 "Health care service" means any medical or behavioral  
12 health service covered under the medical assistance program  
13 that is rendered in the inpatient or outpatient hospital  
14 setting, including hospital-based clinics, and subject to  
15 review under a service authorization program.

16 "Provider" means an individual actively enrolled in the  
17 medical assistance program and licensed or otherwise  
18 authorized to order, prescribe, refer, or render health care  
19 services in this State, and, as determined by the Department,  
20 may also include hospitals that submit service authorization  
21 requests.

22 "Service authorization exemption" means an exception  
23 granted by a Medicaid MCO to a provider under which all service  
24 authorization requests for covered health care services,  
25 excluding pharmacy services and durable medical equipment, are

1 automatically deemed to be medically necessary, clinically  
2 appropriate, and approved for reimbursement as ordered.

3 "Service authorization program" means any utilization  
4 review, utilization management, peer review, quality review,  
5 or other medical management activity conducted in advance of,  
6 concurrent to, or after the provision of a health care service  
7 by a Medicaid MCO, either directly or through a contracted  
8 utilization review organization (URO), including, but not  
9 limited to, prior authorization, pre-certification,  
10 certification of admission, concurrent review, and  
11 retrospective review of health care services.

12 "Service authorization request" means a request by a  
13 provider to a service authorization program to determine  
14 whether a health care service that is otherwise covered under  
15 the medical assistance program meets the reimbursement  
16 requirements established by the Medicaid MCO, or its  
17 contracted URO, for medically necessary, clinically  
18 appropriate care and to issue a service authorization  
19 determination.

20 "Utilization review organization" or "URO" means a managed  
21 care organization or other entity that has established or  
22 administers one or more service authorization programs.

23 (b) In consultation with the Medicaid MCOs, a statewide  
24 association representing managed care organizations, a  
25 statewide association representing the majority of Illinois  
26 hospitals, and a statewide association representing

1 physicians, the Department shall in accordance with the  
2 Illinois Administrative Procedure Act, adopt administrative  
3 rules no later than July 1, 2026, consistent with this  
4 Section, to require each Medicaid MCO to identify Gold Card  
5 providers with such identification initially being effective  
6 for health care services provided on and after July 1, 2026  
7 ~~2025~~.

8 (c) The Department shall adopt rules, in accordance with  
9 the Illinois Administrative Procedure Act, to implement this  
10 Section that include, but are not limited to, the following  
11 provisions:

12 (1) Require each Medicaid MCO to provide a service  
13 authorization exemption to a provider if the provider has  
14 submitted at least 50 service authorization requests to  
15 its service authorization program in the preceding  
16 calendar year and the service authorization program  
17 approved at least 90% of all service authorization  
18 requests, regardless of the type of health care services  
19 requested.

20 (2) Require that service authorization exemptions be  
21 limited to services provided in an inpatient or outpatient  
22 hospital setting inclusive of hospital-based clinics.  
23 Service authorization exemptions under this Section shall  
24 not pertain to pharmacy services and durable medical  
25 equipment and supplies.

26 (3) The service authorization exemption shall be valid

1 for at least one year, shall be made by each Medicaid MCO  
2 or its URO, and shall be binding on the Medicaid MCO and  
3 its URO.

4 (4) The provider shall be required to continue to  
5 document medically necessary, clinically appropriate care  
6 and submit such documentation to the Medicaid MCO for the  
7 purpose of continuous performance monitoring. If a  
8 provider fails to maintain the 90% service authorization  
9 standard, as determined on no more frequent a basis than  
10 bi-annually, the provider's service authorization  
11 exemption is subject to temporary or permanent suspension.

12 (5) Require that each Medicaid MCO publish on its  
13 provider portal a list of all providers that have  
14 qualified for a service authorization exemption or  
15 indicate that a provider has qualified for a service  
16 authorization exemption on its provider-facing provider  
17 roster.

18 (6) Require that no later than June 1 ~~December 1~~ of  
19 each calendar year, each Medicaid MCO shall provide  
20 written notification to all providers who qualify for a  
21 service authorization exemption, for the subsequent State  
22 fiscal calendar year.

23 (7) Require that each Medicaid MCO or its URO use the  
24 policies and guidelines published by the Department to  
25 evaluate whether a provider meets the criteria to qualify  
26 for a service authorization exemption and the conditions

1 under which a service authorization exemption may be  
2 rescinded, including review of the provider's service  
3 authorization determinations during the preceding calendar  
4 year.

5 (8) Require each Medicaid MCO to provide the  
6 Department a list of all providers who were denied a  
7 service authorization exemption or had a previously  
8 granted service authorization exemption suspended, with  
9 such denials being subject to an annual audit conducted by  
10 an independent third-party URO to ensure their  
11 appropriateness.

12 (A) The independent third-party URO shall issue a  
13 written report consistent with this paragraph.

14 (B) The independent third-party URO shall not be  
15 owned by, affiliated with, or employed by any Medicaid  
16 MCO or its contracted URO, nor shall it have any  
17 financial interest in the Medicaid MCO's service  
18 authorization exemption program.

19 (d) Each Medicaid MCO must have a standard method to  
20 accept and process professional claims and facility claims, as  
21 billed by the provider, for a health care service that is  
22 rendered, prescribed, or ordered by a provider granted a  
23 service authorization exemption, except in cases of fraud.

24 (e) A service authorization program shall not deny,  
25 partially deny, reduce the level of care, or otherwise limit  
26 reimbursement to the rendering or supervising provider,

1 including the rendering facility, for health care services  
2 ordered by a provider who qualifies for a service  
3 authorization exemption, except in cases of fraud.

4 (f) This Section is repealed on December 31, 2030.

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

6 ARTICLE 72.

7 Section 72-5. The Hospital Licensing Act is amended by  
8 changing Section 4.5 as follows:

9 (210 ILCS 85/4.5)

10 Sec. 4.5. Hospital with multiple locations; single  
11 license.

12 (a) A hospital located in a county with fewer than  
13 3,000,000 inhabitants may apply to the Department for approval  
14 to conduct its operations from more than one location within  
15 the county under a single license. At the time of the  
16 application to operate under a single license, a hospital  
17 located in a county with fewer than 125,000 inhabitants may  
18 apply to the Department for approval to conduct its operations  
19 from more than one location within contiguous counties in  
20 which both facilities are located, provided that the second  
21 county has fewer than 235,000 inhabitants. A hospital located  
22 in a county with fewer than 325,000 inhabitants may apply to  
23 the Department for approval to conduct its operations from

1 more than one location within contiguous counties provided  
2 that the facility located in the contiguous county is  
3 separately licensed under this Act and was acquired out of  
4 bankruptcy proceedings under the United States Bankruptcy Code  
5 before the effective date of this amendatory Act of the 104th  
6 General Assembly.

7 (b) The facilities or buildings at those locations must be  
8 owned or operated together by a single corporation or other  
9 legal entity serving as the licensee and must share:

10 (1) a single board of directors with responsibility  
11 for governance, including financial oversight and the  
12 authority to designate or remove the chief executive  
13 officer;

14 (2) a single medical staff accountable to the board of  
15 directors and governed by a single set of medical staff  
16 bylaws, rules, and regulations with responsibility for the  
17 quality of the medical services; and

18 (3) a single chief executive officer, accountable to  
19 the board of directors, with management responsibility.

20 (c) Each hospital building or facility that is located on  
21 a site geographically separate from the campus or premises of  
22 another hospital building or facility operated by the licensee  
23 must, at a minimum, individually comply with the Department's  
24 hospital licensing requirements for emergency services.

25 (d) The hospital shall submit to the Department a  
26 comprehensive plan in relation to the waiver or waivers

1 requested describing the services and operations of each  
2 facility or building and how common services or operations  
3 will be coordinated between the various locations. With the  
4 exception of items required by subsection (c), the Department  
5 is authorized to waive compliance with the hospital licensing  
6 requirements for specific buildings or facilities, provided  
7 that the hospital has documented which other building or  
8 facility under its single license provides that service or  
9 operation, and that doing so would not endanger the public's  
10 health, safety, or welfare. Nothing in this Section relieves a  
11 hospital from the requirements of the Health Facilities  
12 Planning Act.

13 (Source: P.A. 102-887, eff. 5-17-22; 103-1075, eff. 3-21-25.)

14 ARTICLE 73.

15 Section 73-5. The Nursing Home Care Act is amended by  
16 changing Sections 3-202.05 and 3-209 as follows:

17 (210 ILCS 45/3-202.05)

18 Sec. 3-202.05. Staffing ratios effective July 1, 2010 and  
19 thereafter.

20 (a) For the purpose of computing staff to resident ratios,  
21 direct care staff shall include:

22 (1) registered nurses;

23 (2) licensed practical nurses;

- 1 (3) certified nurse assistants;
- 2 (4) psychiatric services rehabilitation aides;
- 3 (5) rehabilitation and therapy aides;
- 4 (6) psychiatric services rehabilitation coordinators;
- 5 (7) assistant directors of nursing;
- 6 (8) 50% of the Director of Nurses' time; and
- 7 (9) 30% of the Social Services Directors' time.

8 The Department shall, by rule, allow certain facilities  
9 subject to 77 Ill. Adm. Code 300.4000 and following (Subpart  
10 S) to utilize specialized clinical staff, as defined in rules,  
11 to count towards the staffing ratios.

12 Within 120 days of June 14, 2012 (the effective date of  
13 Public Act 97-689), the Department shall promulgate rules  
14 specific to the staffing requirements for facilities federally  
15 defined as Institutions for Mental Disease. These rules shall  
16 recognize the unique nature of individuals with chronic mental  
17 health conditions, shall include minimum requirements for  
18 specialized clinical staff, including clinical social workers,  
19 psychiatrists, psychologists, and direct care staff set forth  
20 in paragraphs (4) through (6) and any other specialized staff  
21 which may be utilized and deemed necessary to count toward  
22 staffing ratios.

23 Within 120 days of June 14, 2012 (the effective date of  
24 Public Act 97-689), the Department shall promulgate rules  
25 specific to the staffing requirements for facilities licensed  
26 under the Specialized Mental Health Rehabilitation Act of

1 2013. These rules shall recognize the unique nature of  
2 individuals with chronic mental health conditions, shall  
3 include minimum requirements for specialized clinical staff,  
4 including clinical social workers, psychiatrists,  
5 psychologists, and direct care staff set forth in paragraphs  
6 (4) through (6) and any other specialized staff which may be  
7 utilized and deemed necessary to count toward staffing ratios.

8 (a-5) The Centers for Medicare and Medicaid Services'  
9 payroll-based journal job title codes, which correspond to the  
10 staff used for the staffing ratios in subsection (a), are as  
11 follows:

12 (1) Registered Nurse Director of Nursing, job title  
13 code 5.

14 (2) Registered Nurse with Administrative Duties, job  
15 title code 6.

16 (3) Registered Nurse, job title code 7.

17 (4) Licensed Practical/Vocational Nurse with  
18 Administrative Duties, job title code 8.

19 (5) Licensed Practical/Vocational Nurse, job title  
20 code 9.

21 (6) Certified Nurse Aide, job title code 10.

22 (7) Nurse Aide in Training, job title code 11.

23 (8) Medication Aide/Technician, job title code 12.

24 (9) Nurse Practitioner, job title code 13.

25 (10) Clinical Nurse Specialist, job title code 14.

26 (11) Occupational Therapist, job title code 18.

1           (12) Occupational Therapy Assistant, job title code

2           19.

3           (13) Occupational Therapy Aide, job title code 20.

4           (14) Physical Therapist, job title code 21.

5           (15) Physical Therapy Assistant, job title code 22.

6           (16) Physical Therapy Assistant, job title code 23.

7           (17) Respiratory Therapist, job title code 24.

8           (18) Respiratory Therapy Technician, job title code

9           25.

10          (19) Speech/Language Pathologist, job title code 26.

11          (20) Qualified Activities Professional, job title code

12          28.

13          (21) Other Activities Staff, job title code 29.

14          (22) Qualified Social Worker, job title code 30.

15          (23) Other Social Worker, job title code 31.

16          (24) Mental Health Service Worker, job title code 34.

17          For all job title codes in this subsection, 100% of the  
18          hours worked by the staff must be counted toward the  
19          staff-to-resident ratio, except job code title 5, which is  
20          limited to 50%, and job title codes 28, 30, and 31, which are  
21          limited to 30%.

22          (b) (Blank).

23          (b-5) For purposes of the minimum staffing ratios in this  
24          Section, all residents shall be classified as requiring either  
25          skilled care or intermediate care.

26          As used in this subsection:

1 "Intermediate care" means basic nursing care and other  
2 restorative services under periodic medical direction.

3 "Skilled care" means skilled nursing care, continuous  
4 skilled nursing observations, restorative nursing, and other  
5 services under professional direction with frequent medical  
6 supervision.

7 (c) Facilities shall notify the Department within 60 days  
8 after July 29, 2010 (the effective date of Public Act  
9 96-1372), in a form and manner prescribed by the Department,  
10 of the staffing ratios in effect on July 29, 2010 (the  
11 effective date of Public Act 96-1372) for both intermediate  
12 and skilled care and the number of residents receiving each  
13 level of care.

14 (d) (1) (Blank).

15 (2) (Blank).

16 (3) (Blank).

17 (4) (Blank).

18 (5) Effective January 1, 2014, the minimum staffing ratios  
19 shall be increased to 3.8 hours of nursing and personal care  
20 each day for a resident needing skilled care and 2.5 hours of  
21 nursing and personal care each day for a resident needing  
22 intermediate care.

23 (e) Ninety days after June 14, 2012 (the effective date of  
24 Public Act 97-689), a minimum of 25% of nursing and personal  
25 care time shall be provided by licensed nurses, with at least  
26 10% of nursing and personal care time provided by registered

1 nurses. These minimum requirements shall remain in effect  
2 until an acuity based registered nurse requirement is  
3 promulgated by rule concurrent with the adoption of the  
4 Resource Utilization Group classification-based payment  
5 methodology, as provided in Section 5-5.2 of the Illinois  
6 Public Aid Code. Registered nurses and licensed practical  
7 nurses employed by a facility in excess of these requirements  
8 may be used to satisfy the remaining 75% of the nursing and  
9 personal care time requirements. Notwithstanding this  
10 subsection, no staffing requirement in statute in effect on  
11 June 14, 2012 (the effective date of Public Act 97-689) shall  
12 be reduced on account of this subsection.

13 (f) The Department shall submit proposed rules for  
14 adoption by January 1, 2020 establishing a system for  
15 determining compliance with minimum staffing set forth in this  
16 Section and the requirements of 77 Ill. Adm. Code 300.1230  
17 adjusted for any waivers granted under Section 3-303.1.  
18 Compliance shall be determined quarterly by comparing the  
19 number of hours provided per resident per day using the  
20 Centers for Medicare and Medicaid Services' payroll-based  
21 journal and the facility's daily census, broken down by  
22 intermediate and skilled care as self-reported by the facility  
23 to the Department on a quarterly basis. The Department shall  
24 use the quarterly payroll-based journal and the self-reported  
25 census to calculate the number of hours provided per resident  
26 per day and compare this ratio to the minimum staffing

1 standards required under this Section, as impacted by any  
2 waivers granted under Section 3-303.1. Discrepancies between  
3 job titles contained in this Section and the payroll-based  
4 journal shall be addressed by rule. The manner in which the  
5 Department requests payroll-based journal information to be  
6 submitted shall align with the federal Centers for Medicare  
7 and Medicaid Services' requirements that allow providers to  
8 submit the quarterly data in an aggregate manner.

9 (g) Monetary penalties for non-compliance. The Department  
10 shall submit proposed rules for adoption by January 1, 2020  
11 establishing monetary penalties for facilities not in  
12 compliance with minimum staffing standards under this Section.  
13 Facilities shall be required to comply with the provisions of  
14 this subsection beginning January 1, 2025. No monetary penalty  
15 may be issued for noncompliance prior to the revised  
16 implementation date, which shall be January 1, 2025. If a  
17 facility is found to be noncompliant prior to the revised  
18 implementation date, the Department shall provide a written  
19 notice identifying the staffing deficiencies and require the  
20 facility to provide a sufficiently detailed correction plan  
21 that describes proposed and completed actions the facility  
22 will take or has taken, including hiring actions, to address  
23 the facility's failure to meet the statutory minimum staffing  
24 levels. Monetary penalties shall be imposed beginning no later  
25 than July 1, 2025, based on data for the quarter beginning  
26 January 1, 2025 through March 31, 2025 and quarterly

1 thereafter. Monetary penalties shall be established based on a  
2 formula that calculates on a daily basis the cost of wages and  
3 benefits for the missing staffing hours. All notices of  
4 noncompliance shall include the computations used to determine  
5 noncompliance and establishing the variance between minimum  
6 staffing ratios and the Department's computations. The penalty  
7 for the first offense shall be 125% of the cost of wages and  
8 benefits for the missing staffing hours. The penalty shall  
9 increase to 150% of the cost of wages and benefits for the  
10 missing staffing hours for the second offense and 200% the  
11 cost of wages and benefits for the missing staffing hours for  
12 the third and all subsequent offenses. The penalty shall be  
13 imposed regardless of whether the facility has committed other  
14 violations of this Act during the same period that the  
15 staffing offense occurred. The penalty may not be waived,  
16 except ~~but the Department shall have the discretion to~~  
17 ~~determine the gravity of the violation in situations~~ where  
18 there is no more than a 10% deviation from the staffing  
19 requirements, in which case the facility shall not receive a  
20 violation or penalty ~~and make appropriate adjustments to the~~  
21 ~~penalty~~. The Department is granted discretion to waive the  
22 violation and penalty when unforeseen circumstances have  
23 occurred that resulted in call-offs of scheduled staff. This  
24 provision shall be applied no more than 6 times per quarter.  
25 Nothing in this Section diminishes a facility's right to  
26 appeal the imposition of a monetary penalty. No facility may

1 appeal a notice of noncompliance issued during the revised  
2 implementation period. The changes made to this subsection by  
3 this amendatory Act of the 104th General Assembly in regard to  
4 nursing home staffing fines shall apply to the July 1, 2025  
5 fines based on data for the quarter beginning January 1, 2025  
6 through March 31, 2025 and quarterly thereafter.

7 (Source: P.A. 101-10, eff. 6-5-19; 102-16, eff. 6-17-21;  
8 102-1118, eff. 1-18-23.)

9 (210 ILCS 45/3-209) (from Ch. 111 1/2, par. 4153-209)

10 (Text of Section before amendment by P.A. 103-1069)

11 Sec. 3-209. Required posting of information.

12 (a) Every facility shall conspicuously post for display in  
13 an area of its offices accessible to residents, employees, and  
14 visitors the following:

15 (1) Its current license;

16 (2) A description, provided by the Department, of  
17 complaint procedures established under this Act and the  
18 name, address, and telephone number of a person authorized  
19 by the Department to receive complaints;

20 (3) A copy of any order pertaining to the facility  
21 issued by the Department or a court;

22 (4) A list of the material available for public  
23 inspection under Section 3-210;

24 (5) Phone numbers and websites for rights protection  
25 services must be posted in common areas and at the main

1 entrance and provided upon entry and at the request of  
2 residents or the resident's representative in accordance  
3 with 42 CFR 483.10(j)(4); and

4 (6) The statement "The Illinois Long-Term Care  
5 Ombudsman Program is a free resident advocacy service  
6 available to the public."

7 In accordance with F574 of the State Operations Manual for  
8 Long-Term Care Facilities, the administrator shall post for  
9 all residents and at the main entrance the name, address, and  
10 telephone number of the appropriate State governmental office  
11 where complaints may be lodged in language the resident can  
12 understand, which must include notice of the grievance  
13 procedure of the facility or program as well as addresses and  
14 phone numbers for the Office of Health Care Regulation and the  
15 Long-Term Care Ombudsman Program and a website showing the  
16 information of a facility's ownership. The facility shall  
17 include a link to the Long-Term Care Ombudsman Program's  
18 website on the home page of the facility's website.

19 (b) A facility that has received a notice of violation for  
20 a violation of the minimum staffing requirements under Section  
21 3-202.05 shall display, for a consecutive 60 days immediately  
22 after the facility is notified of the violation ~~during the~~  
23 ~~period of time the facility is out of compliance~~, a notice  
24 stating in Calibri (body) font and 26-point type in black  
25 letters on an 8.5 by 11 inch white paper the following:

1 "Notice Dated: .....

2 This facility did ~~does~~ not ~~currently~~ meet the minimum staffing  
3 ratios required by law for [insert applicable quarter]. Posted  
4 at the direction of the Illinois Department of Public  
5 Health."

6 The notice must be posted, at a minimum, at all publicly used  
7 exterior entryways into the facility, inside the main entrance  
8 lobby, and next to any registration desk for easily accessible  
9 viewing. The notice must also be posted on the main page of the  
10 facility's website. The Department shall have the discretion  
11 to determine the gravity of any violation and, taking into  
12 account mitigating and aggravating circumstances and facts,  
13 may reduce the requirement of, and amount of time for, posting  
14 the notice. Facilities shall not be required to post for the  
15 violation if they are within the 10% deviation of staffing  
16 requirements as provided in Section 3-202.05.

17 (Source: P.A. 101-10, eff. 6-5-19; 102-1080, eff. 1-1-23.)

18 (Text of Section after amendment by P.A. 103-1069)

19 Sec. 3-209. Required posting of information.

20 (a) Every facility shall conspicuously post for display in  
21 an area of its offices accessible to residents, employees, and  
22 visitors the following:

23 (1) Its current license;

24 (2) A description, provided by the Department, of

1 complaint procedures established under this Act and the  
2 name, address, and telephone number of a person authorized  
3 by the Department to receive complaints;

4 (3) A copy of any order pertaining to the facility  
5 issued by the Department or a court;

6 (4) A list of the material available for public  
7 inspection under Section 3-210;

8 (5) Phone numbers and websites for rights protection  
9 services must be posted in common areas and at the main  
10 entrance and provided upon entry and at the request of  
11 residents or the resident's representative in accordance  
12 with 42 CFR 483.10(j)(4);

13 (6) The statement "The Illinois Long-Term Care  
14 Ombudsman Program is a free resident advocacy service  
15 available to the public."; and

16 (7) A description of the retaliation complaint  
17 procedures and the remedies established under this Act.

18 In accordance with F574 of the State Operations Manual for  
19 Long-Term Care Facilities, the administrator shall post for  
20 all residents and at the main entrance the name, address, and  
21 telephone number of the appropriate State governmental office  
22 where complaints may be lodged in language the resident can  
23 understand, which must include notice of the grievance  
24 procedure of the facility or program as well as addresses and  
25 phone numbers for the Office of Health Care Regulation and the  
26 Long-Term Care Ombudsman Program and a website showing the

1 information of a facility's ownership. The facility shall  
2 include a link to the Long-Term Care Ombudsman Program's  
3 website on the home page of the facility's website.

4 (b) A facility that has received a notice of violation for  
5 a violation of the minimum staffing requirements under Section  
6 3-202.05 shall display, for a consecutive 60 days immediately  
7 after the facility is notified of the violation ~~during the~~  
8 ~~period of time the facility is out of compliance~~, a notice  
9 stating in Calibri (body) font and 26-point type in black  
10 letters on an 8.5 by 11 inch white paper the following:

11 "Notice Dated: .....

12 This facility did ~~does~~ not ~~currently~~ meet the minimum staffing  
13 ratios required by law for [insert applicable quarter]. Posted  
14 at the direction of the Illinois Department of Public  
15 Health."

16 The notice must be posted, at a minimum, at all publicly used  
17 exterior entryways into the facility, inside the main entrance  
18 lobby, and next to any registration desk for easily accessible  
19 viewing. The notice must also be posted on the main page of the  
20 facility's website. The Department shall have the discretion  
21 to determine the gravity of any violation and, taking into  
22 account mitigating and aggravating circumstances and facts,  
23 may reduce the requirement of, and amount of time for, posting  
24 the notice. Facilities shall not be required to post for the

1 violation if they are within the 10% deviation of staffing  
2 requirements as provided in Section 3-202.05.

3 (Source: P.A. 102-1080, eff. 1-1-23; 103-1069, eff. 1-1-26.)

4 ARTICLE 74.

5 Section 74-5. The Illinois Public Aid Code is amended by  
6 changing Section 5-5.01a as follows:

7 (305 ILCS 5/5-5.01a)

8 Sec. 5-5.01a. Supportive living facilities program.

9 (a) The Department shall establish and provide oversight  
10 for a program of supportive living facilities that seek to  
11 promote resident independence, dignity, respect, and  
12 well-being in the most cost-effective manner.

13 A supportive living facility is (i) a free-standing  
14 facility or (ii) a distinct physical and operational entity  
15 within a mixed-use building that meets the criteria  
16 established in subsection (d). A supportive living facility  
17 integrates housing with health, personal care, and supportive  
18 services and is a designated setting that offers residents  
19 their own separate, private, and distinct living units.

20 Sites for the operation of the program shall be selected  
21 by the Department based upon criteria that may include the  
22 need for services in a geographic area, the availability of  
23 funding, and the site's ability to meet the standards.

1           (b) Beginning July 1, 2014, subject to federal approval,  
2 the Medicaid rates for supportive living facilities shall be  
3 equal to the supportive living facility Medicaid rate  
4 effective on June 30, 2014 increased by 8.85%. Once the  
5 assessment imposed at Article V-G of this Code is determined  
6 to be a permissible tax under Title XIX of the Social Security  
7 Act, the Department shall increase the Medicaid rates for  
8 supportive living facilities effective on July 1, 2014 by  
9 9.09%. The Department shall apply this increase retroactively  
10 to coincide with the imposition of the assessment in Article  
11 V-G of this Code in accordance with the approval for federal  
12 financial participation by the Centers for Medicare and  
13 Medicaid Services.

14           The Medicaid rates for supportive living facilities  
15 effective on July 1, 2017 must be equal to the rates in effect  
16 for supportive living facilities on June 30, 2017 increased by  
17 2.8%.

18           The Medicaid rates for supportive living facilities  
19 effective on July 1, 2018 must be equal to the rates in effect  
20 for supportive living facilities on June 30, 2018.

21           Subject to federal approval, the Medicaid rates for  
22 supportive living services on and after July 1, 2019 must be at  
23 least 54.3% of the average total nursing facility services per  
24 diem for the geographic areas defined by the Department while  
25 maintaining the rate differential for dementia care and must  
26 be updated whenever the total nursing facility service per

1 diems are updated. Beginning July 1, 2022, upon the  
2 implementation of the Patient Driven Payment Model, Medicaid  
3 rates for supportive living services must be at least 54.3% of  
4 the average total nursing services per diem rate for the  
5 geographic areas. For purposes of this provision, the average  
6 total nursing services per diem rate shall include all add-ons  
7 for nursing facilities for the geographic area provided for in  
8 Section 5-5.2. The rate differential for dementia care must be  
9 maintained in these rates and the rates shall be updated  
10 whenever nursing facility per diem rates are updated.

11 Subject to federal approval, beginning January 1, 2024,  
12 the dementia care rate for supportive living services must be  
13 no less than the non-dementia care supportive living services  
14 rate multiplied by 1.5.

15 (b-5) Subject to federal approval, beginning January 1,  
16 2025, Medicaid rates for supportive living services must be at  
17 least 54.75% of the average total nursing facility ~~services~~  
18 per diem rate for the geographic areas defined by the  
19 Department and shall include all add-ons for nursing  
20 facilities for the geographic area provided for in Section  
21 5-5.2.

22 (c) The Department may adopt rules to implement this  
23 Section. Rules that establish or modify the services,  
24 standards, and conditions for participation in the program  
25 shall be adopted by the Department in consultation with the  
26 Department on Aging, the Department of Rehabilitation

1 Services, and the Department of Mental Health and  
2 Developmental Disabilities (or their successor agencies).

3 (d) Subject to federal approval by the Centers for  
4 Medicare and Medicaid Services, the Department shall accept  
5 for consideration of certification under the program any  
6 application for a site or building where distinct parts of the  
7 site or building are designated for purposes other than the  
8 provision of supportive living services, but only if:

9 (1) those distinct parts of the site or building are  
10 not designated for the purpose of providing assisted  
11 living services as required under the Assisted Living and  
12 Shared Housing Act;

13 (2) those distinct parts of the site or building are  
14 completely separate from the part of the building used for  
15 the provision of supportive living program services,  
16 including separate entrances;

17 (3) those distinct parts of the site or building do  
18 not share any common spaces with the part of the building  
19 used for the provision of supportive living program  
20 services; and

21 (4) those distinct parts of the site or building do  
22 not share staffing with the part of the building used for  
23 the provision of supportive living program services.

24 (e) Facilities or distinct parts of facilities which are  
25 selected as supportive living facilities and are in good  
26 standing with the Department's rules are exempt from the

1 provisions of the Nursing Home Care Act and the Illinois  
2 Health Facilities Planning Act.

3 (f) Section 9817 of the American Rescue Plan Act of 2021  
4 (Public Law 117-2) authorizes a 10% enhanced federal medical  
5 assistance percentage for supportive living services for a  
6 12-month period from April 1, 2021 through March 31, 2022.  
7 Subject to federal approval, including the approval of any  
8 necessary waiver amendments or other federally required  
9 documents or assurances, for a 12-month period the Department  
10 must pay a supplemental \$26 per diem rate to all supportive  
11 living facilities with the additional federal financial  
12 participation funds that result from the enhanced federal  
13 medical assistance percentage from April 1, 2021 through March  
14 31, 2022. The Department may issue parameters around how the  
15 supplemental payment should be spent, including quality  
16 improvement activities. The Department may alter the form,  
17 methods, or timeframes concerning the supplemental per diem  
18 rate to comply with any subsequent changes to federal law,  
19 changes made by guidance issued by the federal Centers for  
20 Medicare and Medicaid Services, or other changes necessary to  
21 receive the enhanced federal medical assistance percentage.

22 (g) All applications for the expansion of supportive  
23 living dementia care settings involving sites not approved by  
24 the Department by January 1, 2024 (Public Act 103-102) may  
25 allow new elderly non-dementia units in addition to new  
26 dementia care units. The Department may approve such

1 applications only if the application has: (1) no more than one  
2 non-dementia care unit for each dementia care unit and (2) the  
3 site is not located within 4 miles of an existing supportive  
4 living program site in Cook County (including the City of  
5 Chicago), not located within 12 miles of an existing  
6 supportive living program site in Alexander, Bond, Boone,  
7 Calhoun, Champaign, Clinton, DeKalb, DuPage Fulton, Grundy,  
8 Henry, Jackson, Jersey, Johnson, Kane, Kankakee, Kendall,  
9 Lake, Macon, Macoupin, Madison, Marshall, McHenry, McLean,  
10 Menard, Mercer, Monroe, Peoria, Piatt, Rock Island, Sangamon,  
11 Stark, St. Clair, Tazewell, Vermilion, Will, Williamson,  
12 Winnebago, or Woodford counties, or not located within 25  
13 miles of an existing supportive living program site in any  
14 other county.

15 (h) Beginning January 1, 2025, subject to federal  
16 approval, for a person who is a resident of a supportive living  
17 facility under this Section, the monthly personal needs  
18 allowance shall be \$120 per month.

19 (i) ~~(h)~~ As stated in the supportive living program home  
20 and community-based service waiver approved by the federal  
21 Centers for Medicare and Medicaid Services, and beginning July  
22 1, 2025, the Department must maintain the rate add-on  
23 implemented on January 1, 2023 for the provision of 2 meals per  
24 day at no less than \$6.15 per day.

25 (j) ~~(f)~~ Subject to federal approval, the Department shall  
26 allow a certified medication aide to administer medication in

1 a supportive living facility. For purposes of this subsection,  
2 "certified medication aide" means a person who has met the  
3 qualifications for certification under Section 79 of the  
4 Assisted Living and Shared Housing Act and assists with  
5 medication administration while under the supervision of a  
6 registered professional nurse as authorized by Section 50-75  
7 of the Nurse Practice Act. The Department may adopt rules to  
8 implement this subsection.

9 (Source: P.A. 102-43, eff. 7-6-21; 102-699, eff. 4-19-22;  
10 103-102, Article 20, Section 20-5, eff. 1-1-24; 103-102,  
11 Article 100, Section 100-5, eff. 1-1-24; 103-593, Article 15,  
12 Section 15-5, eff. 6-7-24; 103-593, Article 100, Section  
13 100-5, eff. 6-7-24; 103-593, Article 165, Section 165-5, eff.  
14 6-7-24; 103-605, eff. 7-1-24; 103-886, eff. 8-9-24; revised  
15 10-8-24.)

16 ARTICLE 75.

17 Section 75-5. The Illinois Public Aid Code is amended by  
18 changing Section 5A-2 as follows:

19 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

20 (Section scheduled to be repealed on December 31, 2026)

21 Sec. 5A-2. Assessment.

22 (a) (1) Subject to Sections 5A-3 and 5A-10, for State  
23 fiscal years 2009 through 2018, or as long as continued under

1 Section 5A-16, an annual assessment on inpatient services is  
2 imposed on each hospital provider in an amount equal to  
3 \$218.38 multiplied by the difference of the hospital's  
4 occupied bed days less the hospital's Medicare bed days,  
5 provided, however, that the amount of \$218.38 shall be  
6 increased by a uniform percentage to generate an amount equal  
7 to 75% of the State share of the payments authorized under  
8 Section 5A-12.5, with such increase only taking effect upon  
9 the date that a State share for such payments is required under  
10 federal law. For the period of April through June 2015, the  
11 amount of \$218.38 used to calculate the assessment under this  
12 paragraph shall, by emergency rule under subsection (s) of  
13 Section 5-45 of the Illinois Administrative Procedure Act, be  
14 increased by a uniform percentage to generate \$20,250,000 in  
15 the aggregate for that period from all hospitals subject to  
16 the annual assessment under this paragraph.

17 (2) In addition to any other assessments imposed under  
18 this Article, effective July 1, 2016 and semi-annually  
19 thereafter through June 2018, or as provided in Section 5A-16,  
20 in addition to any federally required State share as  
21 authorized under paragraph (1), the amount of \$218.38 shall be  
22 increased by a uniform percentage to generate an amount equal  
23 to 75% of the ACA Assessment Adjustment, as defined in  
24 subsection (b-6) of this Section.

25 For State fiscal years 2009 through 2018, or as provided  
26 in Section 5A-16, a hospital's occupied bed days and Medicare

1 bed days shall be determined using the most recent data  
2 available from each hospital's 2005 Medicare cost report as  
3 contained in the Healthcare Cost Report Information System  
4 file, for the quarter ending on December 31, 2006, without  
5 regard to any subsequent adjustments or changes to such data.  
6 If a hospital's 2005 Medicare cost report is not contained in  
7 the Healthcare Cost Report Information System, then the  
8 Illinois Department may obtain the hospital provider's  
9 occupied bed days and Medicare bed days from any source  
10 available, including, but not limited to, records maintained  
11 by the hospital provider, which may be inspected at all times  
12 during business hours of the day by the Illinois Department or  
13 its duly authorized agents and employees.

14 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State  
15 fiscal years 2019 and 2020, an annual assessment on inpatient  
16 services is imposed on each hospital provider in an amount  
17 equal to \$197.19 multiplied by the difference of the  
18 hospital's occupied bed days less the hospital's Medicare bed  
19 days. For State fiscal years 2019 and 2020, a hospital's  
20 occupied bed days and Medicare bed days shall be determined  
21 using the most recent data available from each hospital's 2015  
22 Medicare cost report as contained in the Healthcare Cost  
23 Report Information System file, for the quarter ending on  
24 March 31, 2017, without regard to any subsequent adjustments  
25 or changes to such data. If a hospital's 2015 Medicare cost  
26 report is not contained in the Healthcare Cost Report

1 Information System, then the Illinois Department may obtain  
2 the hospital provider's occupied bed days and Medicare bed  
3 days from any source available, including, but not limited to,  
4 records maintained by the hospital provider, which may be  
5 inspected at all times during business hours of the day by the  
6 Illinois Department or its duly authorized agents and  
7 employees. Notwithstanding any other provision in this  
8 Article, for a hospital provider that did not have a 2015  
9 Medicare cost report, but paid an assessment in State fiscal  
10 year 2018 on the basis of hypothetical data, that assessment  
11 amount shall be used for State fiscal years 2019 and 2020.

12 (4) Subject to Sections 5A-3 and 5A-10 and to subsection  
13 (b-8), for the period of July 1, 2020 through December 31, 2020  
14 and calendar years 2021 through 2026, an annual assessment on  
15 inpatient services is imposed on each hospital provider in an  
16 amount equal to \$221.50 multiplied by the difference of the  
17 hospital's occupied bed days less the hospital's Medicare bed  
18 days, provided however: for the period of July 1, 2020 through  
19 December 31, 2020, (i) the assessment shall be equal to 50% of  
20 the annual amount; and (ii) the amount of \$221.50 shall be  
21 retroactively adjusted by a uniform percentage to generate an  
22 amount equal to 50% of the Assessment Adjustment, as defined  
23 in subsection (b-7). For the period of July 1, 2020 through  
24 December 31, 2020 and calendar years 2021 through 2026, a  
25 hospital's occupied bed days and Medicare bed days shall be  
26 determined using the most recent data available from each

1 hospital's 2015 Medicare cost report as contained in the  
2 Healthcare Cost Report Information System file, for the  
3 quarter ending on March 31, 2017, without regard to any  
4 subsequent adjustments or changes to such data. If a  
5 hospital's 2015 Medicare cost report is not contained in the  
6 Healthcare Cost Report Information System, then the Illinois  
7 Department may obtain the hospital provider's occupied bed  
8 days and Medicare bed days from any source available,  
9 including, but not limited to, records maintained by the  
10 hospital provider, which may be inspected at all times during  
11 business hours of the day by the Illinois Department or its  
12 duly authorized agents and employees. Should the change in the  
13 assessment methodology for fiscal years 2021 through December  
14 31, 2022 not be approved on or before June 30, 2020, the  
15 assessment and payments under this Article in effect for  
16 fiscal year 2020 shall remain in place until the new  
17 assessment is approved. If the assessment methodology for July  
18 1, 2020 through December 31, 2022, is approved on or after July  
19 1, 2020, it shall be retroactive to July 1, 2020, subject to  
20 federal approval and provided that the payments authorized  
21 under Section 5A-12.7 have the same effective date as the new  
22 assessment methodology. In giving retroactive effect to the  
23 assessment approved after June 30, 2020, credit toward the new  
24 assessment shall be given for any payments of the previous  
25 assessment for periods after June 30, 2020. Notwithstanding  
26 any other provision of this Article, for a hospital provider

1 that did not have a 2015 Medicare cost report, but paid an  
2 assessment in State Fiscal Year 2020 on the basis of  
3 hypothetical data, the data that was the basis for the 2020  
4 assessment shall be used to calculate the assessment under  
5 this paragraph until December 31, 2023. Beginning July 1, 2022  
6 and through December 31, 2024, a safety-net hospital that had  
7 a change of ownership in calendar year 2021, and whose  
8 inpatient utilization had decreased by 90% from the prior year  
9 and prior to the change of ownership, may be eligible to pay a  
10 tax based on hypothetical data based on a determination of  
11 financial distress by the Department. Subject to federal  
12 approval, the Department may, by January 1, 2024, develop a  
13 hypothetical tax for a specialty cancer hospital which had a  
14 structural change of ownership during calendar year 2022 from  
15 a for-profit entity to a non-profit entity, and which has  
16 experienced a decline of 60% or greater in inpatient days of  
17 care as compared to the prior owners 2015 Medicare cost  
18 report. This change of ownership may make the hospital  
19 eligible for a hypothetical tax under the new hospital  
20 provision of the assessment defined in this Section. This new  
21 hypothetical tax may be applicable from January 1, 2024  
22 through December 31, 2026.

23 (6) For calendar year 2026, and for each year thereafter  
24 in which a tax is imposed under this Section, the Department  
25 may seek to obtain a waiver from the federal Centers for  
26 Medicare and Medicaid Services of the uniformity requirements

1 in place for the tax imposed under this Section, provided that  
2 such waiver request does not risk the assessment imposed or  
3 payments authorized under this Section from continuing. Such  
4 uniformity requirements shall only be waived for  
5 not-for-profit hospitals operating as a freestanding cancer  
6 hospital that have contracted to provide services to members  
7 served by at least 50% of the managed care organizations  
8 contracted with the Department. Such tax rates imposed on a  
9 hospital shall be no more than 50% and no less than 25% of the  
10 tax imposed on all other hospitals in this State unless  
11 different rates are necessary to meet federal statistical  
12 tests necessary for continued federal financial participation.  
13 Upon federal approval of such a waiver, other tax rates  
14 imposed under this Article shall be adjusted to ensure budget  
15 neutrality.

16 (b) (Blank).

17 (b-5) (1) Subject to Sections 5A-3 and 5A-10, for the  
18 portion of State fiscal year 2012, beginning June 10, 2012  
19 through June 30, 2012, and for State fiscal years 2013 through  
20 2018, or as provided in Section 5A-16, an annual assessment on  
21 outpatient services is imposed on each hospital provider in an  
22 amount equal to .008766 multiplied by the hospital's  
23 outpatient gross revenue, provided, however, that the amount  
24 of .008766 shall be increased by a uniform percentage to  
25 generate an amount equal to 25% of the State share of the  
26 payments authorized under Section 5A-12.5, with such increase

1 only taking effect upon the date that a State share for such  
2 payments is required under federal law. For the period  
3 beginning June 10, 2012 through June 30, 2012, the annual  
4 assessment on outpatient services shall be prorated by  
5 multiplying the assessment amount by a fraction, the numerator  
6 of which is 21 days and the denominator of which is 365 days.  
7 For the period of April through June 2015, the amount of  
8 .008766 used to calculate the assessment under this paragraph  
9 shall, by emergency rule under subsection (s) of Section 5-45  
10 of the Illinois Administrative Procedure Act, be increased by  
11 a uniform percentage to generate \$6,750,000 in the aggregate  
12 for that period from all hospitals subject to the annual  
13 assessment under this paragraph.

14 (2) In addition to any other assessments imposed under  
15 this Article, effective July 1, 2016 and semi-annually  
16 thereafter through June 2018, in addition to any federally  
17 required State share as authorized under paragraph (1), the  
18 amount of .008766 shall be increased by a uniform percentage  
19 to generate an amount equal to 25% of the ACA Assessment  
20 Adjustment, as defined in subsection (b-6) of this Section.

21 For the portion of State fiscal year 2012, beginning June  
22 10, 2012 through June 30, 2012, and State fiscal years 2013  
23 through 2018, or as provided in Section 5A-16, a hospital's  
24 outpatient gross revenue shall be determined using the most  
25 recent data available from each hospital's 2009 Medicare cost  
26 report as contained in the Healthcare Cost Report Information

1 System file, for the quarter ending on June 30, 2011, without  
2 regard to any subsequent adjustments or changes to such data.  
3 If a hospital's 2009 Medicare cost report is not contained in  
4 the Healthcare Cost Report Information System, then the  
5 Department may obtain the hospital provider's outpatient gross  
6 revenue from any source available, including, but not limited  
7 to, records maintained by the hospital provider, which may be  
8 inspected at all times during business hours of the day by the  
9 Department or its duly authorized agents and employees.

10 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State  
11 fiscal years 2019 and 2020, an annual assessment on outpatient  
12 services is imposed on each hospital provider in an amount  
13 equal to .01358 multiplied by the hospital's outpatient gross  
14 revenue. For State fiscal years 2019 and 2020, a hospital's  
15 outpatient gross revenue shall be determined using the most  
16 recent data available from each hospital's 2015 Medicare cost  
17 report as contained in the Healthcare Cost Report Information  
18 System file, for the quarter ending on March 31, 2017, without  
19 regard to any subsequent adjustments or changes to such data.  
20 If a hospital's 2015 Medicare cost report is not contained in  
21 the Healthcare Cost Report Information System, then the  
22 Department may obtain the hospital provider's outpatient gross  
23 revenue from any source available, including, but not limited  
24 to, records maintained by the hospital provider, which may be  
25 inspected at all times during business hours of the day by the  
26 Department or its duly authorized agents and employees.

1 Notwithstanding any other provision in this Article, for a  
2 hospital provider that did not have a 2015 Medicare cost  
3 report, but paid an assessment in State fiscal year 2018 on the  
4 basis of hypothetical data, that assessment amount shall be  
5 used for State fiscal years 2019 and 2020.

6 (4) Subject to Sections 5A-3 and 5A-10 and to subsection  
7 (b-8), for the period of July 1, 2020 through December 31, 2020  
8 and calendar years 2021 through 2026, an annual assessment on  
9 outpatient services is imposed on each hospital provider in an  
10 amount equal to .01525 multiplied by the hospital's outpatient  
11 gross revenue, provided however: (i) for the period of July 1,  
12 2020 through December 31, 2020, the assessment shall be equal  
13 to 50% of the annual amount; and (ii) the amount of .01525  
14 shall be retroactively adjusted by a uniform percentage to  
15 generate an amount equal to 50% of the Assessment Adjustment,  
16 as defined in subsection (b-7). For the period of July 1, 2020  
17 through December 31, 2020 and calendar years 2021 through  
18 2026, a hospital's outpatient gross revenue shall be  
19 determined using the most recent data available from each  
20 hospital's 2015 Medicare cost report as contained in the  
21 Healthcare Cost Report Information System file, for the  
22 quarter ending on March 31, 2017, without regard to any  
23 subsequent adjustments or changes to such data. If a  
24 hospital's 2015 Medicare cost report is not contained in the  
25 Healthcare Cost Report Information System, then the Illinois  
26 Department may obtain the hospital provider's outpatient

1 revenue data from any source available, including, but not  
2 limited to, records maintained by the hospital provider, which  
3 may be inspected at all times during business hours of the day  
4 by the Illinois Department or its duly authorized agents and  
5 employees. Should the change in the assessment methodology  
6 above for fiscal years 2021 through calendar year 2022 not be  
7 approved prior to July 1, 2020, the assessment and payments  
8 under this Article in effect for fiscal year 2020 shall remain  
9 in place until the new assessment is approved. If the change in  
10 the assessment methodology above for July 1, 2020 through  
11 December 31, 2022, is approved after June 30, 2020, it shall  
12 have a retroactive effective date of July 1, 2020, subject to  
13 federal approval and provided that the payments authorized  
14 under Section 12A-7 have the same effective date as the new  
15 assessment methodology. In giving retroactive effect to the  
16 assessment approved after June 30, 2020, credit toward the new  
17 assessment shall be given for any payments of the previous  
18 assessment for periods after June 30, 2020. Notwithstanding  
19 any other provision of this Article, for a hospital provider  
20 that did not have a 2015 Medicare cost report, but paid an  
21 assessment in State Fiscal Year 2020 on the basis of  
22 hypothetical data, the data that was the basis for the 2020  
23 assessment shall be used to calculate the assessment under  
24 this paragraph until December 31, 2023. Beginning July 1, 2022  
25 and through December 31, 2024, a safety-net hospital that had  
26 a change of ownership in calendar year 2021, and whose

1 inpatient utilization had decreased by 90% from the prior year  
2 and prior to the change of ownership, may be eligible to pay a  
3 tax based on hypothetical data based on a determination of  
4 financial distress by the Department.

5 (6) For calendar year 2026, and for each year thereafter  
6 in which a tax is imposed under this Section, the Department  
7 may seek to obtain a waiver from the federal Centers for  
8 Medicare and Medicaid Services of the uniformity requirements  
9 in place for the tax imposed under this Section, provided that  
10 such waiver request does not risk the assessment imposed or  
11 payments authorized under this Section from continuing. Such  
12 uniformity requirements shall only be waived for  
13 not-for-profit hospitals operating as a freestanding cancer  
14 hospital that have contracted to provide services to members  
15 served by at least 50% of the managed care organizations  
16 contracted with the Department. Such tax rates imposed on a  
17 hospital shall be no more than 50% and no less than 25% of the  
18 tax imposed on all other hospitals in this State unless  
19 different rates are necessary to meet federal statistical  
20 tests necessary for continued federal financial participation.  
21 Upon federal approval of such a waiver, other tax rates  
22 imposed under this Article shall be adjusted to ensure budget  
23 neutrality.

24 (b-6) (1) As used in this Section, "ACA Assessment  
25 Adjustment" means:

26 (A) For the period of July 1, 2016 through December

1 31, 2016, the product of .19125 multiplied by the sum of  
2 the fee-for-service payments to hospitals as authorized  
3 under Section 5A-12.5 and the adjustments authorized under  
4 subsection (t) of Section 5A-12.2 to managed care  
5 organizations for hospital services due and payable in the  
6 month of April 2016 multiplied by 6.

7 (B) For the period of January 1, 2017 through June 30,  
8 2017, the product of .19125 multiplied by the sum of the  
9 fee-for-service payments to hospitals as authorized under  
10 Section 5A-12.5 and the adjustments authorized under  
11 subsection (t) of Section 5A-12.2 to managed care  
12 organizations for hospital services due and payable in the  
13 month of October 2016 multiplied by 6, except that the  
14 amount calculated under this subparagraph (B) shall be  
15 adjusted, either positively or negatively, to account for  
16 the difference between the actual payments issued under  
17 Section 5A-12.5 for the period beginning July 1, 2016  
18 through December 31, 2016 and the estimated payments due  
19 and payable in the month of April 2016 multiplied by 6 as  
20 described in subparagraph (A).

21 (C) For the period of July 1, 2017 through December  
22 31, 2017, the product of .19125 multiplied by the sum of  
23 the fee-for-service payments to hospitals as authorized  
24 under Section 5A-12.5 and the adjustments authorized under  
25 subsection (t) of Section 5A-12.2 to managed care  
26 organizations for hospital services due and payable in the

1 month of April 2017 multiplied by 6, except that the  
2 amount calculated under this subparagraph (C) shall be  
3 adjusted, either positively or negatively, to account for  
4 the difference between the actual payments issued under  
5 Section 5A-12.5 for the period beginning January 1, 2017  
6 through June 30, 2017 and the estimated payments due and  
7 payable in the month of October 2016 multiplied by 6 as  
8 described in subparagraph (B).

9 (D) For the period of January 1, 2018 through June 30,  
10 2018, the product of .19125 multiplied by the sum of the  
11 fee-for-service payments to hospitals as authorized under  
12 Section 5A-12.5 and the adjustments authorized under  
13 subsection (t) of Section 5A-12.2 to managed care  
14 organizations for hospital services due and payable in the  
15 month of October 2017 multiplied by 6, except that:

16 (i) the amount calculated under this subparagraph  
17 (D) shall be adjusted, either positively or  
18 negatively, to account for the difference between the  
19 actual payments issued under Section 5A-12.5 for the  
20 period of July 1, 2017 through December 31, 2017 and  
21 the estimated payments due and payable in the month of  
22 April 2017 multiplied by 6 as described in  
23 subparagraph (C); and

24 (ii) the amount calculated under this subparagraph  
25 (D) shall be adjusted to include the product of .19125  
26 multiplied by the sum of the fee-for-service payments,

1 if any, estimated to be paid to hospitals under  
2 subsection (b) of Section 5A-12.5.

3 (2) The Department shall complete and apply a final  
4 reconciliation of the ACA Assessment Adjustment prior to June  
5 30, 2018 to account for:

6 (A) any differences between the actual payments issued  
7 or scheduled to be issued prior to June 30, 2018 as  
8 authorized in Section 5A-12.5 for the period of January 1,  
9 2018 through June 30, 2018 and the estimated payments due  
10 and payable in the month of October 2017 multiplied by 6 as  
11 described in subparagraph (D); and

12 (B) any difference between the estimated  
13 fee-for-service payments under subsection (b) of Section  
14 5A-12.5 and the amount of such payments that are actually  
15 scheduled to be paid.

16 The Department shall notify hospitals of any additional  
17 amounts owed or reduction credits to be applied to the June  
18 2018 ACA Assessment Adjustment. This is to be considered the  
19 final reconciliation for the ACA Assessment Adjustment.

20 (3) Notwithstanding any other provision of this Section,  
21 if for any reason the scheduled payments under subsection (b)  
22 of Section 5A-12.5 are not issued in full by the final day of  
23 the period authorized under subsection (b) of Section 5A-12.5,  
24 funds collected from each hospital pursuant to subparagraph  
25 (D) of paragraph (1) and pursuant to paragraph (2),  
26 attributable to the scheduled payments authorized under

1 subsection (b) of Section 5A-12.5 that are not issued in full  
2 by the final day of the period attributable to each payment  
3 authorized under subsection (b) of Section 5A-12.5, shall be  
4 refunded.

5 (4) The increases authorized under paragraph (2) of  
6 subsection (a) and paragraph (2) of subsection (b-5) shall be  
7 limited to the federally required State share of the total  
8 payments authorized under Section 5A-12.5 if the sum of such  
9 payments yields an annualized amount equal to or less than  
10 \$450,000,000, or if the adjustments authorized under  
11 subsection (t) of Section 5A-12.2 are found not to be  
12 actuarially sound; however, this limitation shall not apply to  
13 the fee-for-service payments described in subsection (b) of  
14 Section 5A-12.5.

15 (b-7)(1) As used in this Section, "Assessment Adjustment"  
16 means:

17 (A) For the period of July 1, 2020 through December  
18 31, 2020, the product of .3853 multiplied by the total of  
19 the actual payments made under subsections (c) through (k)  
20 of Section 5A-12.7 attributable to the period, less the  
21 total of the assessment imposed under subsections (a) and  
22 (b-5) of this Section for the period.

23 (B) For each calendar quarter beginning January 1,  
24 2021 through December 31, 2022, the product of .3853  
25 multiplied by the total of the actual payments made under  
26 subsections (c) through (k) of Section 5A-12.7

1           attributable to the period, less the total of the  
2           assessment imposed under subsections (a) and (b-5) of this  
3           Section for the period.

4           (C) Beginning on January 1, 2023, and each subsequent  
5           July 1 and January 1, the product of .3853 multiplied by  
6           the total of the actual payments made under subsections  
7           (c) through (j) of Section 5A-12.7 attributable to the  
8           6-month period immediately preceding the period to which  
9           the adjustment applies, less the total of the assessment  
10          imposed under subsections (a) and (b-5) of this Section  
11          for the 6-month period immediately preceding the period to  
12          which the adjustment applies.

13          (2) The Department shall calculate and notify each  
14          hospital of the total Assessment Adjustment and any additional  
15          assessment owed by the hospital or refund owed to the hospital  
16          on either a semi-annual or annual basis. Such notice shall be  
17          issued at least 30 days prior to any period in which the  
18          assessment will be adjusted. Any additional assessment owed by  
19          the hospital or refund owed to the hospital shall be uniformly  
20          applied to the assessment owed by the hospital in monthly  
21          installments for the subsequent semi-annual period or calendar  
22          year. If no assessment is owed in the subsequent year, any  
23          amount owed by the hospital or refund due to the hospital,  
24          shall be paid in a lump sum.

25          (3) The Department shall publish all details of the  
26          Assessment Adjustment calculation performed each year on its

1 website within 30 days of completing the calculation, and also  
2 submit the details of the Assessment Adjustment calculation as  
3 part of the Department's annual report to the General  
4 Assembly.

5 (b-8) Notwithstanding any other provision of this Article,  
6 the Department shall reduce the assessments imposed on each  
7 hospital under subsections (a) and (b-5) by the uniform  
8 percentage necessary to reduce the total assessment imposed on  
9 all hospitals by an aggregate amount of \$240,000,000, with  
10 such reduction being applied by June 30, 2022. The assessment  
11 reduction required for each hospital under this subsection  
12 shall be forever waived, forgiven, and released by the  
13 Department.

14 (c) (Blank).

15 (d) Notwithstanding any of the other provisions of this  
16 Section, the Department is authorized to adopt rules to reduce  
17 the rate of any annual assessment imposed under this Section,  
18 as authorized by Section 5-46.2 of the Illinois Administrative  
19 Procedure Act.

20 (e) Notwithstanding any other provision of this Section,  
21 any plan providing for an assessment on a hospital provider as  
22 a permissible tax under Title XIX of the federal Social  
23 Security Act and Medicaid-eligible payments to hospital  
24 providers from the revenues derived from that assessment shall  
25 be reviewed by the Illinois Department of Healthcare and  
26 Family Services, as the Single State Medicaid Agency required

1 by federal law, to determine whether those assessments and  
2 hospital provider payments meet federal Medicaid standards. If  
3 the Department determines that the elements of the plan may  
4 meet federal Medicaid standards and a related State Medicaid  
5 Plan Amendment is prepared in a manner and form suitable for  
6 submission, that State Plan Amendment shall be submitted in a  
7 timely manner for review by the Centers for Medicare and  
8 Medicaid Services of the United States Department of Health  
9 and Human Services and subject to approval by the Centers for  
10 Medicare and Medicaid Services of the United States Department  
11 of Health and Human Services. No such plan shall become  
12 effective without approval by the Illinois General Assembly by  
13 the enactment into law of related legislation. Notwithstanding  
14 any other provision of this Section, the Department is  
15 authorized to adopt rules to reduce the rate of any annual  
16 assessment imposed under this Section. Any such rules may be  
17 adopted by the Department under Section 5-50 of the Illinois  
18 Administrative Procedure Act.

19 (Source: P.A. 102-886, eff. 5-17-22; 103-102, eff. 1-1-24.)

20 ARTICLE 800.

21 Section 800-95. No acceleration or delay. Where this Act  
22 makes changes in a statute that is represented in this Act by  
23 text that is not yet or no longer in effect (for example, a  
24 Section represented by multiple versions), the use of that

1 text does not accelerate or delay the taking effect of (i) the  
2 changes made by this Act or (ii) provisions derived from any  
3 other Public Act.

4 ARTICLE 999.

5 Section 999-99. Effective date. This Act takes effect upon  
6 becoming law, except that Article 10 takes effect January 1,  
7 2026.".