Rep. Anna Moeller

Filed: 5/31/2025

AMENDMENT TO SENATE BILL 2437

AMENDMENT NO. _____. Amend Senate Bill 2437 by replacing everything after the enacting clause with the following:

"ARTICLE 2.

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

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

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

(1) is 18 years of age or older;

(2) has the following relationship with the family

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

(i) spouse;

(ii) sibling or stepsibling;

(iii) parent, stepparent, or adoptive parent;

(iv) grandparent;

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

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

(vii) legal guardian; or

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

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

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

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

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

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

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

(ii) medication administration;

(iii) enteral care and therapy; and

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

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

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

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

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

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

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

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

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

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

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

(210 ILCS 3/35)

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

(1) (Blank).

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

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

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

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

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

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

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

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

diagnostic studies typically done in the home setting.

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

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

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

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

who receive home health benefits.

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

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

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

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

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

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

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

(1) A part of a hospital; or

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

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

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

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

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

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

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

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

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

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

administered at the center.

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

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

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

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

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

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

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

(i) Birth center ownership.

(ii) Sources of payment for services.

(iii) Utilization data involving patient length of stay.

(iv) Admissions and discharges.

(v) Complications.

(vi) Transfers.

(vii) Unusual incidents.

(viii) Deaths.

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

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

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

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

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

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

(210 ILCS 55/2.11)

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

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

(210 ILCS 55/2.13 new)

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

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

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

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

(210 ILCS 85/17 new)

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

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

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

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

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

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

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

licensed under the provisions of this Act.

(b) This Act does not prohibit the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) (Blank).

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

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

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

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

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

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

(305 ILCS 5/5-2.06b new)

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

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

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

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

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

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

ARTICLE 5.

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

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

(305 ILCS 5/5-18.6 new)

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

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

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

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

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

inconsistent with generally accepted medical standards or practices.

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

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

(305 ILCS 5/5-18.7 new)

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

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

ARTICLE 10.

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

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

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

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

2. Beginning January 1, 2014, persons otherwise

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

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

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

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

(b) (Blank).

3. (Blank).

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

expenses.

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

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

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

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

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

(b) Children and youth who are under temporary custody

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

7. (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) meet one of the following conditions:

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

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

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

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

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

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

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

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

15. Family Care Eligibility.

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

(b) Eligibility shall be reviewed annually.

(c) (Blank).

(d) (Blank).

(e) (Blank).

(f) (Blank).

(g) (Blank).

(h) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

benefits.

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

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

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

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

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

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

ARTICLE 15.

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

(305 ILCS 5/5-5.09a new)

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

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

and community-based settings.

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

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

ARTICLE 20.

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

(305 ILCS 5/5-5.12f)

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

utilization or prior approval mandates.

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

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

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

(3) subject to federal law on maximum dosage limits

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

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

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

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

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

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

(1) Delusional Disorder (F22)

(2) Brief Psychotic Disorder (F23)

(3) Schizophreniform Disorder (F20.81)

(4) Schizophrenia (F20.9)

(5) Schizoaffective Disorder (F25.x)

(6) Catatonia Associated with Another Mental Disorder (Catatonia Specifier) (F06.1)

(7) Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (F28)

(8) Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (F29)

(9) Bipolar I Disorder (F31.xx)

(10) Bipolar II Disorder (F31.81)

(11) Cyclothymic Disorder (F34.0)

(12) Unspecified Bipolar and Related Disorder (F31.9)

(13) Disruptive Mood Dysregulation Disorder (F34.8)

(14) Major Depressive Disorder Single episode (F32.xx)

(15) Major Depressive Disorder, Recurrent episode (F33.xx)

(16) Obsessive-Compulsive Disorder (F42)

(17) Posttraumatic Stress Disorder (F43.10)

(18) Anorexia Nervosa (F50.0x)

(19) Bulimia Nervosa (F50.2)

(20) Postpartum Depression (F53.0)

(21) Puerperal Psychosis (F53.1)

(22) Factitious Disorder Imposed on Another (F68.A)

(d) Notwithstanding any other provision of law, nothing in

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

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

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

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

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

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

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

(6) The number of persons enrolled in the medical

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

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

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

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

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

ARTICLE 30.

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

(305 ILCS 5/5-2b)

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

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

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

services on December 31, 2023.

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

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

provide further analysis in the support of the evaluation.

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

ARTICLE 35.

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

(305 ILCS 5/5-65 new)

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

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

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

ARTICLE 40.

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

(305 ILCS 5/5-5)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Department shall not impose a deductible, coinsurance,

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

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

For purposes of this Section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Illinois Department, in cooperation with the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

when local government funds finance federal participation for claims payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

organizations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Palliative Care Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For purposes of this Section:

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

"Diagnostic mammography" means a method of screening that

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

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

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

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

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

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

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

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

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

cancer treatment quality program.

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

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

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

The Department shall establish a performance goal for

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

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

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

in-network covered benefit.

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

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

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

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

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

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

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

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

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

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

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

the Illinois Health Finance Reform Act, except that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight. The Illinois Department shall develop, in cooperation with other State departments and agencies, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. At a minimum, and to the extent necessary to provide data sharing, the Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, including, but not limited to: the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

whatever reason, is unauthorized.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 45.

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

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

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

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

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

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

ARTICLE 66.

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

(305 ILCS 5/14-12)

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

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

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

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

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

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

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

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

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

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

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

(7.5) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2018.

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

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

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

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

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

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

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

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

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

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

(2) After the transition period, if the Department

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

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

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

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

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

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

(2) Phase 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(F) Entities eligible to be funded.

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

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

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

communities, $30,000,000 of transformation funds to projects that are a collaboration between hospitals and other providers in distressed areas of the State designed to address specific health care ~~healthcare~~ disparities, $15,000,000 to collaborations between critical access hospitals and other providers designed to address specific health care ~~healthcare~~ disparities, and $15,000,000 to cross-provider collaborations designed to address specific health care ~~healthcare~~ disparities, and $5,000,000 to collaborations that focus on workforce development.

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

project will be approved.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 67.

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

(305 ILCS 5/10-3.5 new)

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

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

ARTICLE 68.

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

(5 ILCS 100/5-45.65 new)

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

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

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

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

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

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

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

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

(2) serious impairment to bodily functions;

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

(4) inadequately controlled pain; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) (Blank).

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

(1) The MCO shall not impose any service authorization

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

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

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

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

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

they still were within the contracting area.

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

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

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

(6) The MCO's financial responsibility for

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

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

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

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

(D) the enrollee is discharged.

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

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

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

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

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

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

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

(f) Network adequacy and transparency.

(1) The Department shall:

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

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

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

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

(E) require MCOs to ensure that any

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

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

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

successor agency.

(g) Timely payment of claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

The rules shall be applicable for both MCO coverage and fee-for-service coverage.

If the fee-for-service system is ultimately determined to have been responsible for coverage on the date of service, the Department shall provide for an extended period for claims submission outside the standard timely filing requirements.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of metrics:

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

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

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

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

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

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

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

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

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

(A) Premium revenue, with appropriate adjustments.

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

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

(iv) Direct reserves.

(v) Gross recoveries.

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

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

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

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

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

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

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

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

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

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

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

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

(g-13) Utilization Review Standardization and Transparency.

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) provide a written report to the General

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

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

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

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

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

(j) Health care information released to managed care

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

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

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

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

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

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

(305 ILCS 5/5-30.18)

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

Sec. 5-30.18. Service authorization program performance.

(a) Definitions. As used in this Section:

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The service authorization exemption shall be valid

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 72.

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

(210 ILCS 85/4.5)

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 73.

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

(210 ILCS 45/3-202.05)

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

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

(1) registered nurses;

(2) licensed practical nurses;

(3) certified nurse assistants;

(4) psychiatric services rehabilitation aides;

(5) rehabilitation and therapy aides;

(6) psychiatric services rehabilitation coordinators;

(7) assistant directors of nursing;

(8) 50% of the Director of Nurses' time; and

(9) 30% of the Social Services Directors' time.

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

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

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

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

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

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

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

(3) Registered Nurse, job title code 7.

(4) Licensed Practical/Vocational Nurse with Administrative Duties, job title code 8.

(5) Licensed Practical/Vocational Nurse, job title code 9.

(6) Certified Nurse Aide, job title code 10.

(7) Nurse Aide in Training, job title code 11.

(8) Medication Aide/Technician, job title code 12.

(9) Nurse Practitioner, job title code 13.

(10) Clinical Nurse Specialist, job title code 14.

(11) Occupational Therapist, job title code 18.

(12) Occupational Therapy Assistant, job title code 19.

(13) Occupational Therapy Aide, job title code 20.

(14) Physical Therapist, job title code 21.

(15) Physical Therapy Assistant, job title code 22.

(16) Physical Therapy Assistant, job title code 23.

(17) Respiratory Therapist, job title code 24.

(18) Respiratory Therapy Technician, job title code 25.

(19) Speech/Language Pathologist, job title code 26.

(20) Qualified Activities Professional, job title code 28.

(21) Other Activities Staff, job title code 29.

(22) Qualified Social Worker, job title code 30.

(23) Other Social Worker, job title code 31.

(24) Mental Health Service Worker, job title code 34.

For all job title codes in this subsection, 100% of the hours worked by the staff must be counted toward the staff-to-resident ratio, except job code title 5, which is limited to 50%, and job title codes 28, 30, and 31, which are limited to 30%.

(b) (Blank).

(b-5) For purposes of the minimum staffing ratios in this Section, all residents shall be classified as requiring either skilled care or intermediate care.

As used in this subsection:

"Intermediate care" means basic nursing care and other restorative services under periodic medical direction.

"Skilled care" means skilled nursing care, continuous skilled nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision.

(c) Facilities shall notify the Department within 60 days after July 29, 2010 (the effective date of Public Act 96-1372), in a form and manner prescribed by the Department, of the staffing ratios in effect on July 29, 2010 (the effective date of Public Act 96-1372) for both intermediate and skilled care and the number of residents receiving each level of care.

(d)(1) (Blank).

(2) (Blank).

(3) (Blank).

(4) (Blank).

(5) Effective January 1, 2014, the minimum staffing ratios shall be increased to 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and personal care each day for a resident needing intermediate care.

(e) Ninety days after June 14, 2012 (the effective date of Public Act 97-689), a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered

nurses. These minimum requirements shall remain in effect until an acuity based registered nurse requirement is promulgated by rule concurrent with the adoption of the Resource Utilization Group classification-based payment methodology, as provided in Section 5-5.2 of the Illinois Public Aid Code. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. Notwithstanding this subsection, no staffing requirement in statute in effect on June 14, 2012 (the effective date of Public Act 97-689) shall be reduced on account of this subsection.

(f) The Department shall submit proposed rules for adoption by January 1, 2020 establishing a system for determining compliance with minimum staffing set forth in this Section and the requirements of 77 Ill. Adm. Code 300.1230 adjusted for any waivers granted under Section 3-303.1. Compliance shall be determined quarterly by comparing the number of hours provided per resident per day using the Centers for Medicare and Medicaid Services' payroll-based journal and the facility's daily census, broken down by intermediate and skilled care as self-reported by the facility to the Department on a quarterly basis. The Department shall use the quarterly payroll-based journal and the self-reported census to calculate the number of hours provided per resident per day and compare this ratio to the minimum staffing

standards required under this Section, as impacted by any waivers granted under Section 3-303.1. Discrepancies between job titles contained in this Section and the payroll-based journal shall be addressed by rule. The manner in which the Department requests payroll-based journal information to be submitted shall align with the federal Centers for Medicare and Medicaid Services' requirements that allow providers to submit the quarterly data in an aggregate manner.

(g) Monetary penalties for non-compliance. The Department shall submit proposed rules for adoption by January 1, 2020 establishing monetary penalties for facilities not in compliance with minimum staffing standards under this Section. Facilities shall be required to comply with the provisions of this subsection beginning January 1, 2025. No monetary penalty may be issued for noncompliance prior to the revised implementation date, which shall be January 1, 2025. If a facility is found to be noncompliant prior to the revised implementation date, the Department shall provide a written notice identifying the staffing deficiencies and require the facility to provide a sufficiently detailed correction plan that describes proposed and completed actions the facility will take or has taken, including hiring actions, to address the facility's failure to meet the statutory minimum staffing levels. Monetary penalties shall be imposed beginning no later than July 1, 2025, based on data for the quarter beginning January 1, 2025 through March 31, 2025 and quarterly

thereafter. Monetary penalties shall be established based on a formula that calculates on a daily basis the cost of wages and benefits for the missing staffing hours. All notices of noncompliance shall include the computations used to determine noncompliance and establishing the variance between minimum staffing ratios and the Department's computations. The penalty for the first offense shall be 125% of the cost of wages and benefits for the missing staffing hours. The penalty shall increase to 150% of the cost of wages and benefits for the missing staffing hours for the second offense and 200% the cost of wages and benefits for the missing staffing hours for the third and all subsequent offenses. The penalty shall be imposed regardless of whether the facility has committed other violations of this Act during the same period that the staffing offense occurred. The penalty may not be waived, except ~~but the Department shall have the discretion to determine the gravity of the violation in situations~~ where there is no more than a 10% deviation from the staffing requirements, in which case the facility shall not receive a violation or penalty ~~and make appropriate adjustments to the penalty~~. The Department is granted discretion to waive the violation and penalty when unforeseen circumstances have occurred that resulted in call-offs of scheduled staff. This provision shall be applied no more than 6 times per quarter. Nothing in this Section diminishes a facility's right to appeal the imposition of a monetary penalty. No facility may

appeal a notice of noncompliance issued during the revised implementation period. The changes made to this subsection by this amendatory Act of the 104th General Assembly in regard to nursing home staffing fines shall apply to the July 1, 2025 fines based on data for the quarter beginning January 1, 2025 through March 31, 2025 and quarterly thereafter.

(Source: P.A. 101-10, eff. 6-5-19; 102-16, eff. 6-17-21; 102-1118, eff. 1-18-23.)

(210 ILCS 45/3-209) (from Ch. 111 1/2, par. 4153-209)

(Text of Section before amendment by P.A. 103-1069)

Sec. 3-209. Required posting of information.

(a) Every facility shall conspicuously post for display in an area of its offices accessible to residents, employees, and visitors the following:

(1) Its current license;

(2) A description, provided by the Department, of complaint procedures established under this Act and the name, address, and telephone number of a person authorized by the Department to receive complaints;

(3) A copy of any order pertaining to the facility issued by the Department or a court;

(4) A list of the material available for public inspection under Section 3-210;

(5) Phone numbers and websites for rights protection services must be posted in common areas and at the main

entrance and provided upon entry and at the request of residents or the resident's representative in accordance with 42 CFR 483.10(j)(4); and

(6) The statement "The Illinois Long-Term Care Ombudsman Program is a free resident advocacy service available to the public.".

In accordance with F574 of the State Operations Manual for Long-Term Care Facilities, the administrator shall post for all residents and at the main entrance the name, address, and telephone number of the appropriate State governmental office where complaints may be lodged in language the resident can understand, which must include notice of the grievance procedure of the facility or program as well as addresses and phone numbers for the Office of Health Care Regulation and the Long-Term Care Ombudsman Program and a website showing the information of a facility's ownership. The facility shall include a link to the Long-Term Care Ombudsman Program's website on the home page of the facility's website.

(b) A facility that has received a notice of violation for a violation of the minimum staffing requirements under Section 3-202.05 shall display, for a consecutive 60 days immediately after the facility is notified of the violation ~~during the period of time the facility is out of compliance~~, a notice stating in Calibri (body) font and 26-point type in black letters on an 8.5 by 11 inch white paper the following:

"Notice Dated: .....
This facility did ~~does~~ not ~~currently~~ meet the minimum staffing ratios required by law for [insert applicable quarter]. Posted at the direction of the Illinois Department of Public Health.".

The notice must be posted, at a minimum, at all publicly used exterior entryways into the facility, inside the main entrance lobby, and next to any registration desk for easily accessible viewing. The notice must also be posted on the main page of the facility's website. The Department shall have the discretion to determine the gravity of any violation and, taking into account mitigating and aggravating circumstances and facts, may reduce the requirement of, and amount of time for, posting the notice. Facilities shall not be required to post for the violation if they are within the 10% deviation of staffing requirements as provided in Section 3-202.05.

(Source: P.A. 101-10, eff. 6-5-19; 102-1080, eff. 1-1-23.)

(Text of Section after amendment by P.A. 103-1069)

Sec. 3-209. Required posting of information.

(a) Every facility shall conspicuously post for display in an area of its offices accessible to residents, employees, and visitors the following:

(1) Its current license;

(2) A description, provided by the Department, of

complaint procedures established under this Act and the name, address, and telephone number of a person authorized by the Department to receive complaints;

(3) A copy of any order pertaining to the facility issued by the Department or a court;

(4) A list of the material available for public inspection under Section 3-210;

(5) Phone numbers and websites for rights protection services must be posted in common areas and at the main entrance and provided upon entry and at the request of residents or the resident's representative in accordance with 42 CFR 483.10(j)(4);

(6) The statement "The Illinois Long-Term Care Ombudsman Program is a free resident advocacy service available to the public."; and

(7) A description of the retaliation complaint procedures and the remedies established under this Act.

In accordance with F574 of the State Operations Manual for Long-Term Care Facilities, the administrator shall post for all residents and at the main entrance the name, address, and telephone number of the appropriate State governmental office where complaints may be lodged in language the resident can understand, which must include notice of the grievance procedure of the facility or program as well as addresses and phone numbers for the Office of Health Care Regulation and the Long-Term Care Ombudsman Program and a website showing the

information of a facility's ownership. The facility shall include a link to the Long-Term Care Ombudsman Program's website on the home page of the facility's website.

(b) A facility that has received a notice of violation for a violation of the minimum staffing requirements under Section 3-202.05 shall display, for a consecutive 60 days immediately after the facility is notified of the violation ~~during the period of time the facility is out of compliance~~, a notice stating in Calibri (body) font and 26-point type in black letters on an 8.5 by 11 inch white paper the following:

"Notice Dated: .....
This facility did ~~does~~ not ~~currently~~ meet the minimum staffing ratios required by law for [insert applicable quarter]. Posted at the direction of the Illinois Department of Public Health.".

The notice must be posted, at a minimum, at all publicly used exterior entryways into the facility, inside the main entrance lobby, and next to any registration desk for easily accessible viewing. The notice must also be posted on the main page of the facility's website. The Department shall have the discretion to determine the gravity of any violation and, taking into account mitigating and aggravating circumstances and facts, may reduce the requirement of, and amount of time for, posting the notice. Facilities shall not be required to post for the

violation if they are within the 10% deviation of staffing requirements as provided in Section 3-202.05.

(Source: P.A. 102-1080, eff. 1-1-23; 103-1069, eff. 1-1-26.)

ARTICLE 74.

Section 74-5. The Illinois Public Aid Code is amended by changing Section 5-5.01a as follows:

(305 ILCS 5/5-5.01a)

Sec. 5-5.01a. Supportive living facilities program.

(a) The Department shall establish and provide oversight for a program of supportive living facilities that seek to promote resident independence, dignity, respect, and well-being in the most cost-effective manner.

A supportive living facility is (i) a free-standing facility or (ii) a distinct physical and operational entity within a mixed-use building that meets the criteria established in subsection (d). A supportive living facility integrates housing with health, personal care, and supportive services and is a designated setting that offers residents their own separate, private, and distinct living units.

Sites for the operation of the program shall be selected by the Department based upon criteria that may include the need for services in a geographic area, the availability of funding, and the site's ability to meet the standards.

(b) Beginning July 1, 2014, subject to federal approval, the Medicaid rates for supportive living facilities shall be equal to the supportive living facility Medicaid rate effective on June 30, 2014 increased by 8.85%. Once the assessment imposed at Article V-G of this Code is determined to be a permissible tax under Title XIX of the Social Security Act, the Department shall increase the Medicaid rates for supportive living facilities effective on July 1, 2014 by 9.09%. The Department shall apply this increase retroactively to coincide with the imposition of the assessment in Article V-G of this Code in accordance with the approval for federal financial participation by the Centers for Medicare and Medicaid Services.

The Medicaid rates for supportive living facilities effective on July 1, 2017 must be equal to the rates in effect for supportive living facilities on June 30, 2017 increased by 2.8%.

The Medicaid rates for supportive living facilities effective on July 1, 2018 must be equal to the rates in effect for supportive living facilities on June 30, 2018.

Subject to federal approval, the Medicaid rates for supportive living services on and after July 1, 2019 must be at least 54.3% of the average total nursing facility services per diem for the geographic areas defined by the Department while maintaining the rate differential for dementia care and must be updated whenever the total nursing facility service per

diems are updated. Beginning July 1, 2022, upon the implementation of the Patient Driven Payment Model, Medicaid rates for supportive living services must be at least 54.3% of the average total nursing services per diem rate for the geographic areas. For purposes of this provision, the average total nursing services per diem rate shall include all add-ons for nursing facilities for the geographic area provided for in Section 5-5.2. The rate differential for dementia care must be maintained in these rates and the rates shall be updated whenever nursing facility per diem rates are updated.

Subject to federal approval, beginning January 1, 2024, the dementia care rate for supportive living services must be no less than the non-dementia care supportive living services rate multiplied by 1.5.

(b-5) Subject to federal approval, beginning January 1, 2025, Medicaid rates for supportive living services must be at least 54.75% of the average total nursing facility ~~services~~ per diem rate for the geographic areas defined by the Department and shall include all add-ons for nursing facilities for the geographic area provided for in Section 5-5.2.

(c) The Department may adopt rules to implement this Section. Rules that establish or modify the services, standards, and conditions for participation in the program shall be adopted by the Department in consultation with the Department on Aging, the Department of Rehabilitation

Services, and the Department of Mental Health and Developmental Disabilities (or their successor agencies).

(d) Subject to federal approval by the Centers for Medicare and Medicaid Services, the Department shall accept for consideration of certification under the program any application for a site or building where distinct parts of the site or building are designated for purposes other than the provision of supportive living services, but only if:

(1) those distinct parts of the site or building are not designated for the purpose of providing assisted living services as required under the Assisted Living and Shared Housing Act;

(2) those distinct parts of the site or building are completely separate from the part of the building used for the provision of supportive living program services, including separate entrances;

(3) those distinct parts of the site or building do not share any common spaces with the part of the building used for the provision of supportive living program services; and

(4) those distinct parts of the site or building do not share staffing with the part of the building used for the provision of supportive living program services.

(e) Facilities or distinct parts of facilities which are selected as supportive living facilities and are in good standing with the Department's rules are exempt from the

provisions of the Nursing Home Care Act and the Illinois Health Facilities Planning Act.

(f) Section 9817 of the American Rescue Plan Act of 2021 (Public Law 117-2) authorizes a 10% enhanced federal medical assistance percentage for supportive living services for a 12-month period from April 1, 2021 through March 31, 2022. Subject to federal approval, including the approval of any necessary waiver amendments or other federally required documents or assurances, for a 12-month period the Department must pay a supplemental $26 per diem rate to all supportive living facilities with the additional federal financial participation funds that result from the enhanced federal medical assistance percentage from April 1, 2021 through March 31, 2022. The Department may issue parameters around how the supplemental payment should be spent, including quality improvement activities. The Department may alter the form, methods, or timeframes concerning the supplemental per diem rate to comply with any subsequent changes to federal law, changes made by guidance issued by the federal Centers for Medicare and Medicaid Services, or other changes necessary to receive the enhanced federal medical assistance percentage.

(g) All applications for the expansion of supportive living dementia care settings involving sites not approved by the Department by January 1, 2024 (Public Act 103-102) may allow new elderly non-dementia units in addition to new dementia care units. The Department may approve such

applications only if the application has: (1) no more than one non-dementia care unit for each dementia care unit and (2) the site is not located within 4 miles of an existing supportive living program site in Cook County (including the City of Chicago), not located within 12 miles of an existing supportive living program site in Alexander, Bond, Boone, Calhoun, Champaign, Clinton, DeKalb, DuPage Fulton, Grundy, Henry, Jackson, Jersey, Johnson, Kane, Kankakee, Kendall, Lake, Macon, Macoupin, Madison, Marshall, McHenry, McLean, Menard, Mercer, Monroe, Peoria, Piatt, Rock Island, Sangamon, Stark, St. Clair, Tazewell, Vermilion, Will, Williamson, Winnebago, or Woodford counties, or not located within 25 miles of an existing supportive living program site in any other county.

(h) Beginning January 1, 2025, subject to federal approval, for a person who is a resident of a supportive living facility under this Section, the monthly personal needs allowance shall be $120 per month.

(i) ~~(h)~~ As stated in the supportive living program home and community-based service waiver approved by the federal Centers for Medicare and Medicaid Services, and beginning July 1, 2025, the Department must maintain the rate add-on implemented on January 1, 2023 for the provision of 2 meals per day at no less than $6.15 per day.

(j) ~~(f)~~ Subject to federal approval, the Department shall allow a certified medication aide to administer medication in

a supportive living facility. For purposes of this subsection, "certified medication aide" means a person who has met the qualifications for certification under Section 79 of the Assisted Living and Shared Housing Act and assists with medication administration while under the supervision of a registered professional nurse as authorized by Section 50-75 of the Nurse Practice Act. The Department may adopt rules to implement this subsection.

(Source: P.A. 102-43, eff. 7-6-21; 102-699, eff. 4-19-22; 103-102, Article 20, Section 20-5, eff. 1-1-24; 103-102, Article 100, Section 100-5, eff. 1-1-24; 103-593, Article 15, Section 15-5, eff. 6-7-24; 103-593, Article 100, Section 100-5, eff. 6-7-24; 103-593, Article 165, Section 165-5, eff. 6-7-24; 103-605, eff. 7-1-24; 103-886, eff. 8-9-24; revised 10-8-24.)

ARTICLE 75.

Section 75-5. The Illinois Public Aid Code is amended by changing Section 5A-2 as follows:

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

(Section scheduled to be repealed on December 31, 2026)

Sec. 5A-2. Assessment.

(a)(1) Subject to Sections 5A-3 and 5A-10, for State fiscal years 2009 through 2018, or as long as continued under

Section 5A-16, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided, however, that the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the State share of the payments authorized under Section 5A-12.5, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period of April through June 2015, the amount of $218.38 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $20,250,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually thereafter through June 2018, or as provided in Section 5A-16, in addition to any federally required State share as authorized under paragraph (1), the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

For State fiscal years 2009 through 2018, or as provided in Section 5A-16, a hospital's occupied bed days and Medicare

bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.

(3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $197.19 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days. For State fiscal years 2019 and 2020, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report

Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

(4) Subject to Sections 5A-3 and 5A-10 and to subsection (b-8), for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2026, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $221.50 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided however: for the period of July 1, 2020 through December 31, 2020, (i) the assessment shall be equal to 50% of the annual amount; and (ii) the amount of $221.50 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment, as defined in subsection (b-7). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2026, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each

hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Should the change in the assessment methodology for fiscal years 2021 through December 31, 2022 not be approved on or before June 30, 2020, the assessment and payments under this Article in effect for fiscal year 2020 shall remain in place until the new assessment is approved. If the assessment methodology for July 1, 2020 through December 31, 2022, is approved on or after July 1, 2020, it shall be retroactive to July 1, 2020, subject to federal approval and provided that the payments authorized under Section 5A-12.7 have the same effective date as the new assessment methodology. In giving retroactive effect to the assessment approved after June 30, 2020, credit toward the new assessment shall be given for any payments of the previous assessment for periods after June 30, 2020. Notwithstanding any other provision of this Article, for a hospital provider

that did not have a 2015 Medicare cost report, but paid an assessment in State Fiscal Year 2020 on the basis of hypothetical data, the data that was the basis for the 2020 assessment shall be used to calculate the assessment under this paragraph until December 31, 2023. Beginning July 1, 2022 and through December 31, 2024, a safety-net hospital that had a change of ownership in calendar year 2021, and whose inpatient utilization had decreased by 90% from the prior year and prior to the change of ownership, may be eligible to pay a tax based on hypothetical data based on a determination of financial distress by the Department. Subject to federal approval, the Department may, by January 1, 2024, develop a hypothetical tax for a specialty cancer hospital which had a structural change of ownership during calendar year 2022 from a for-profit entity to a non-profit entity, and which has experienced a decline of 60% or greater in inpatient days of care as compared to the prior owners 2015 Medicare cost report. This change of ownership may make the hospital eligible for a hypothetical tax under the new hospital provision of the assessment defined in this Section. This new hypothetical tax may be applicable from January 1, 2024 through December 31, 2026.

(6) For calendar year 2026, and for each year thereafter in which a tax is imposed under this Section, the Department may seek to obtain a waiver from the federal Centers for Medicare and Medicaid Services of the uniformity requirements

in place for the tax imposed under this Section, provided that such waiver request does not risk the assessment imposed or payments authorized under this Section from continuing. Such uniformity requirements shall only be waived for not-for-profit hospitals operating as a freestanding cancer hospital that have contracted to provide services to members served by at least 50% of the managed care organizations contracted with the Department. Such tax rates imposed on a hospital shall be no more than 50% and no less than 25% of the tax imposed on all other hospitals in this State unless different rates are necessary to meet federal statistical tests necessary for continued federal financial participation. Upon federal approval of such a waiver, other tax rates imposed under this Article shall be adjusted to ensure budget neutrality.

(b) (Blank).

(b-5)(1) Subject to Sections 5A-3 and 5A-10, for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018, or as provided in Section 5A-16, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue, provided, however, that the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 5A-12.5, with such increase

only taking effect upon the date that a State share for such payments is required under federal law. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days. For the period of April through June 2015, the amount of .008766 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $6,750,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually thereafter through June 2018, in addition to any federally required State share as authorized under paragraph (1), the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

For the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and State fiscal years 2013 through 2018, or as provided in Section 5A-16, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information

System file, for the quarter ending on June 30, 2011, without regard to any subsequent adjustments or changes to such data. If a hospital's 2009 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

(3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01358 multiplied by the hospital's outpatient gross revenue. For State fiscal years 2019 and 2020, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

(4) Subject to Sections 5A-3 and 5A-10 and to subsection (b-8), for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2026, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01525 multiplied by the hospital's outpatient gross revenue, provided however: (i) for the period of July 1, 2020 through December 31, 2020, the assessment shall be equal to 50% of the annual amount; and (ii) the amount of .01525 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment, as defined in subsection (b-7). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2026, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's outpatient

revenue data from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Should the change in the assessment methodology above for fiscal years 2021 through calendar year 2022 not be approved prior to July 1, 2020, the assessment and payments under this Article in effect for fiscal year 2020 shall remain in place until the new assessment is approved. If the change in the assessment methodology above for July 1, 2020 through December 31, 2022, is approved after June 30, 2020, it shall have a retroactive effective date of July 1, 2020, subject to federal approval and provided that the payments authorized under Section 12A-7 have the same effective date as the new assessment methodology. In giving retroactive effect to the assessment approved after June 30, 2020, credit toward the new assessment shall be given for any payments of the previous assessment for periods after June 30, 2020. Notwithstanding any other provision of this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State Fiscal Year 2020 on the basis of hypothetical data, the data that was the basis for the 2020 assessment shall be used to calculate the assessment under this paragraph until December 31, 2023. Beginning July 1, 2022 and through December 31, 2024, a safety-net hospital that had a change of ownership in calendar year 2021, and whose

inpatient utilization had decreased by 90% from the prior year and prior to the change of ownership, may be eligible to pay a tax based on hypothetical data based on a determination of financial distress by the Department.

(6) For calendar year 2026, and for each year thereafter in which a tax is imposed under this Section, the Department may seek to obtain a waiver from the federal Centers for Medicare and Medicaid Services of the uniformity requirements in place for the tax imposed under this Section, provided that such waiver request does not risk the assessment imposed or payments authorized under this Section from continuing. Such uniformity requirements shall only be waived for not-for-profit hospitals operating as a freestanding cancer hospital that have contracted to provide services to members served by at least 50% of the managed care organizations contracted with the Department. Such tax rates imposed on a hospital shall be no more than 50% and no less than 25% of the tax imposed on all other hospitals in this State unless different rates are necessary to meet federal statistical tests necessary for continued federal financial participation. Upon federal approval of such a waiver, other tax rates imposed under this Article shall be adjusted to ensure budget neutrality.

(b-6)(1) As used in this Section, "ACA Assessment Adjustment" means:

(A) For the period of July 1, 2016 through December

31, 2016, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of April 2016 multiplied by 6.

(B) For the period of January 1, 2017 through June 30, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2016 multiplied by 6, except that the amount calculated under this subparagraph (B) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period beginning July 1, 2016 through December 31, 2016 and the estimated payments due and payable in the month of April 2016 multiplied by 6 as described in subparagraph (A).

(C) For the period of July 1, 2017 through December 31, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the

month of April 2017 multiplied by 6, except that the amount calculated under this subparagraph (C) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period beginning January 1, 2017 through June 30, 2017 and the estimated payments due and payable in the month of October 2016 multiplied by 6 as described in subparagraph (B).

(D) For the period of January 1, 2018 through June 30, 2018, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2017 multiplied by 6, except that:

(i) the amount calculated under this subparagraph (D) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period of July 1, 2017 through December 31, 2017 and the estimated payments due and payable in the month of April 2017 multiplied by 6 as described in subparagraph (C); and

(ii) the amount calculated under this subparagraph (D) shall be adjusted to include the product of .19125 multiplied by the sum of the fee-for-service payments,

if any, estimated to be paid to hospitals under subsection (b) of Section 5A-12.5.

(2) The Department shall complete and apply a final reconciliation of the ACA Assessment Adjustment prior to June 30, 2018 to account for:

(A) any differences between the actual payments issued or scheduled to be issued prior to June 30, 2018 as authorized in Section 5A-12.5 for the period of January 1, 2018 through June 30, 2018 and the estimated payments due and payable in the month of October 2017 multiplied by 6 as described in subparagraph (D); and

(B) any difference between the estimated fee-for-service payments under subsection (b) of Section 5A-12.5 and the amount of such payments that are actually scheduled to be paid.

The Department shall notify hospitals of any additional amounts owed or reduction credits to be applied to the June 2018 ACA Assessment Adjustment. This is to be considered the final reconciliation for the ACA Assessment Adjustment.

(3) Notwithstanding any other provision of this Section, if for any reason the scheduled payments under subsection (b) of Section 5A-12.5 are not issued in full by the final day of the period authorized under subsection (b) of Section 5A-12.5, funds collected from each hospital pursuant to subparagraph (D) of paragraph (1) and pursuant to paragraph (2), attributable to the scheduled payments authorized under

subsection (b) of Section 5A-12.5 that are not issued in full by the final day of the period attributable to each payment authorized under subsection (b) of Section 5A-12.5, shall be refunded.

(4) The increases authorized under paragraph (2) of subsection (a) and paragraph (2) of subsection (b-5) shall be limited to the federally required State share of the total payments authorized under Section 5A-12.5 if the sum of such payments yields an annualized amount equal to or less than $450,000,000, or if the adjustments authorized under subsection (t) of Section 5A-12.2 are found not to be actuarially sound; however, this limitation shall not apply to the fee-for-service payments described in subsection (b) of Section 5A-12.5.

(b-7)(1) As used in this Section, "Assessment Adjustment" means:

(A) For the period of July 1, 2020 through December 31, 2020, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (k) of Section 5A-12.7 attributable to the period, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the period.

(B) For each calendar quarter beginning January 1, 2021 through December 31, 2022, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (k) of Section 5A-12.7

attributable to the period, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the period.

(C) Beginning on January 1, 2023, and each subsequent July 1 and January 1, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (j) of Section 5A-12.7 attributable to the 6-month period immediately preceding the period to which the adjustment applies, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the 6-month period immediately preceding the period to which the adjustment applies.

(2) The Department shall calculate and notify each hospital of the total Assessment Adjustment and any additional assessment owed by the hospital or refund owed to the hospital on either a semi-annual or annual basis. Such notice shall be issued at least 30 days prior to any period in which the assessment will be adjusted. Any additional assessment owed by the hospital or refund owed to the hospital shall be uniformly applied to the assessment owed by the hospital in monthly installments for the subsequent semi-annual period or calendar year. If no assessment is owed in the subsequent year, any amount owed by the hospital or refund due to the hospital, shall be paid in a lump sum.

(3) The Department shall publish all details of the Assessment Adjustment calculation performed each year on its

website within 30 days of completing the calculation, and also submit the details of the Assessment Adjustment calculation as part of the Department's annual report to the General Assembly.

(b-8) Notwithstanding any other provision of this Article, the Department shall reduce the assessments imposed on each hospital under subsections (a) and (b-5) by the uniform percentage necessary to reduce the total assessment imposed on all hospitals by an aggregate amount of $240,000,000, with such reduction being applied by June 30, 2022. The assessment reduction required for each hospital under this subsection shall be forever waived, forgiven, and released by the Department.

(c) (Blank).

(d) Notwithstanding any of the other provisions of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section, as authorized by Section 5-46.2 of the Illinois Administrative Procedure Act.

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required

by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois Administrative Procedure Act.

(Source: P.A. 102-886, eff. 5-17-22; 103-102, eff. 1-1-24.)

ARTICLE 800.

Section 800-95. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that

text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

ARTICLE 999.

Section 999-99. Effective date. This Act takes effect upon becoming law, except that Article 10 takes effect January 1, 2026.".