

1 AN ACT concerning public aid.

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

4 ARTICLE 2.

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

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

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

- 13 (1) is 18 years of age or older;
- 14 (2) has the following relationship with the family  
15 member receiving or who is eligible to receive the  
16 services enumerated in this Section:
  - 17 (i) spouse;
  - 18 (ii) sibling or stepsibling;
  - 19 (iii) parent, stepparent, or adoptive parent;
  - 20 (iv) grandparent;
  - 21 (v) mother-in-law or father-in-law;

1 (vi) brother-in-law or sister-in-law;  
2 (vii) legal guardian; or  
3 (viii) caregiver designated by the legally  
4 responsible caregiver as documented in the Medical  
5 Plan of Care;

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

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

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

17 (4) is certified pursuant to this Section to perform  
18 or to assist in performance of services to and for a person  
19 receiving or eligible to receive: (A) in-home shift  
20 nursing services under the Early and Periodic Screening,  
21 Diagnostic and Treatment requirement of Medicaid under 42  
22 U.S.C. 1396d(r); or (B) in-home shift nursing services  
23 through the home and community-based services waiver  
24 program authorized under Section 1915(c) of the Social  
25 Security Act for a designated person or designated persons  
26 who are medically fragile and technology dependent and

1 eligible to receive the services laid out in this Section,  
2 including:

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

5 (ii) medication administration;

6 (iii) enteral care and therapy; and

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

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

11 (a) The Department of Public Health, in partnership with  
12 the Department of Healthcare and Family Services, may create a  
13 certification pathway for a legally responsible caregiver, or  
14 a person who has been designated by a legally responsible  
15 caregiver, who is seeking certification as a certified family  
16 health aide, including the adoption of any necessary rules for  
17 the certification process. This certification pathway shall  
18 include documentation, in a manner designated by the  
19 Department of Public Health, of initial training provided by  
20 hospitals licensed in the Hospital Licensing Act, children's  
21 community-based health care centers as defined in the  
22 Alternative Health Care Delivery Act, or home nursing agencies  
23 as defined in the Home Health, Home Services, and Home Nursing  
24 Agency Licensing Act.

25 (b) A certified family health aide may only perform

1 services to and for a person receiving or eligible to receive:

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

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

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

16 (d) The Department of Public Health, in consultation with  
17 the Department of Healthcare and Family Services, may adopt  
18 rules necessary to implement the provisions of this Act,  
19 including, but not limited to, rules requiring background  
20 checks for the certified family health aide, establishing the  
21 scope of services a certified family health aide can perform,  
22 and establishing any utilization controls of services  
23 performed by a certified family health aide.

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

1 (210 ILCS 3/35)

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

6 (1) (Blank).

7 (2) Alternative health care delivery model;  
8 postsurgical recovery care center. A postsurgical recovery  
9 care center is a designated site which provides  
10 postsurgical recovery care for generally healthy patients  
11 undergoing surgical procedures that potentially require  
12 overnight nursing care, pain control, or observation that  
13 would otherwise be provided in an inpatient setting.  
14 Patients may be discharged from the postsurgical recovery  
15 care center in less than 24 hours if the attending  
16 physician or the facility's medical director believes the  
17 patient has recovered enough to be discharged. A  
18 postsurgical recovery care center is either freestanding  
19 or a defined unit of an ambulatory surgical treatment  
20 center or hospital. No facility, or portion of a facility,  
21 may participate in a demonstration program as a  
22 postsurgical recovery care center unless the facility has  
23 been licensed as an ambulatory surgical treatment center  
24 or hospital for at least 2 years before August 20, 1993  
25 (the effective date of Public Act 88-441). The maximum

1 length of stay for patients in a postsurgical recovery  
2 care center is not to exceed 48 hours unless the treating  
3 physician requests an extension of time from the recovery  
4 center's medical director on the basis of medical or  
5 clinical documentation that an additional care period is  
6 required for the recovery of a patient and the medical  
7 director approves the extension of time. In no case,  
8 however, shall a patient's length of stay in a  
9 postsurgical recovery care center be longer than 72 hours.  
10 If a patient requires an additional care period after the  
11 expiration of the 72-hour limit, the patient shall be  
12 transferred to an appropriate facility. Reports on  
13 variances from the 24-hour or 48-hour limit shall be sent  
14 to the Department for its evaluation. The reports shall,  
15 before submission to the Department, have removed from  
16 them all patient and physician identifiers. Blood products  
17 may be administered in the postsurgical recovery care  
18 center model. In order to handle cases of complications,  
19 emergencies, or exigent circumstances, every postsurgical  
20 recovery care center as defined in this paragraph shall  
21 maintain a contractual relationship, including a transfer  
22 agreement, with a general acute care hospital. A  
23 postsurgical recovery care center shall be no larger than  
24 20 beds. A postsurgical recovery care center shall be  
25 located within 15 minutes travel time from the general  
26 acute care hospital with which the center maintains a

1 contractual relationship, including a transfer agreement,  
2 as required under this paragraph.

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

7 The Department shall adopt rules to implement the  
8 provisions of Public Act 88-441 concerning postsurgical  
9 recovery care centers within 9 months after August 20,  
10 1993. Notwithstanding any other law to the contrary, a  
11 postsurgical recovery care center model may provide sleep  
12 laboratory or similar sleep studies in accordance with  
13 applicable State and federal laws and regulations.

14 (3) Alternative health care delivery model; children's  
15 community-based health care center. A children's  
16 community-based health care center model is a designated  
17 site that provides nursing care, clinical support  
18 services, and therapies for a period of one to 14 days for  
19 short-term stays and 120 days to facilitate transitions to  
20 home or other appropriate settings for medically fragile  
21 children, technology dependent children, and children with  
22 special health care needs who are deemed clinically stable  
23 by a physician and are younger than 22 years of age. This  
24 care is to be provided in a home-like environment that  
25 serves no more than 12 children at a time, except that a  
26 children's community-based health care center in existence

1 on the effective date of this amendatory Act of the 100th  
2 General Assembly that is located in Chicago on grade level  
3 for Life Safety Code purposes may provide care to no more  
4 than 16 children at a time. Children's community-based  
5 health care center services must be available through the  
6 model to all families, including those whose care is paid  
7 for through the Department of Healthcare and Family  
8 Services, the Department of Children and Family Services,  
9 the Department of Human Services, and insurance companies  
10 who cover home health care services or private duty  
11 nursing care in the home.

12 Each children's community-based health care center  
13 model location shall be physically separate and apart from  
14 any other facility licensed by the Department of Public  
15 Health under this or any other Act and shall provide the  
16 following services: respite care, registered nursing or  
17 licensed practical nursing care, transitional care to  
18 facilitate home placement or other appropriate settings  
19 and reunite families, medical day care, weekend camps, and  
20 diagnostic studies typically done in the home setting.

21 A children's community-based health care center may  
22 provide initial training, prior to home placement for, and  
23 shall keep records in a manner designated by the  
24 Department regarding, the certified family health aide, as  
25 defined in the Certified Family Health Aide Program for  
26 Children and Adults Act, identified as the legally

1 responsible caregiver or designated by a legally  
2 responsible caregiver for the medical care of an  
3 individual who receives or is eligible to receive:

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

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

12 Coverage for the services provided by the Department  
13 of Healthcare and Family Services under this paragraph (3)  
14 is contingent upon federal waiver approval and is provided  
15 only to Medicaid eligible clients participating in the  
16 home and community based services waiver designated in  
17 Section 1915(c) of the Social Security Act for medically  
18 frail and technologically dependent children or children  
19 in Department of Children and Family Services foster care  
20 who receive home health benefits.

21 (4) Alternative health care delivery model; community  
22 based residential rehabilitation center. A community-based  
23 residential rehabilitation center model is a designated  
24 site that provides rehabilitation or support, or both, for  
25 persons who have experienced severe brain injury, who are  
26 medically stable, and who no longer require acute

1 rehabilitative care or intense medical or nursing  
2 services. The average length of stay in a community-based  
3 residential rehabilitation center shall not exceed 4  
4 months. As an integral part of the services provided,  
5 individuals are housed in a supervised living setting  
6 while having immediate access to the community. The  
7 residential rehabilitation center authorized by the  
8 Department may have more than one residence included under  
9 the license. A residence may be no larger than 12 beds and  
10 shall be located as an integral part of the community. Day  
11 treatment or individualized outpatient services shall be  
12 provided for persons who reside in their own home.  
13 Functional outcome goals shall be established for each  
14 individual. Services shall include, but are not limited  
15 to, case management, training and assistance with  
16 activities of daily living, nursing consultation,  
17 traditional therapies (physical, occupational, speech),  
18 functional interventions in the residence and community  
19 (job placement, shopping, banking, recreation),  
20 counseling, self-management strategies, productive  
21 activities, and multiple opportunities for skill  
22 acquisition and practice throughout the day. The design of  
23 individualized program plans shall be consistent with the  
24 outcome goals that are established for each resident. The  
25 programs provided in this setting shall be accredited by  
26 the Commission on Accreditation of Rehabilitation

1 Facilities (CARF). The program shall have been accredited  
2 by CARF as a Brain Injury Community-Integrative Program  
3 for at least 3 years.

4 (5) Alternative health care delivery model;  
5 Alzheimer's disease management center. An Alzheimer's  
6 disease management center model is a designated site that  
7 provides a safe and secure setting for care of persons  
8 diagnosed with Alzheimer's disease. An Alzheimer's disease  
9 management center model shall be a facility separate from  
10 any other facility licensed by the Department of Public  
11 Health under this or any other Act. An Alzheimer's disease  
12 management center shall conduct and document an assessment  
13 of each resident every 6 months. The assessment shall  
14 include an evaluation of daily functioning, cognitive  
15 status, other medical conditions, and behavioral problems.  
16 An Alzheimer's disease management center shall develop and  
17 implement an ongoing treatment plan for each resident. The  
18 treatment plan shall have defined goals. The Alzheimer's  
19 disease management center shall treat behavioral problems  
20 and mood disorders using nonpharmacologic approaches such  
21 as environmental modification, task simplification, and  
22 other appropriate activities. All staff must have  
23 necessary training to care for all stages of Alzheimer's  
24 Disease. An Alzheimer's disease management center shall  
25 provide education and support for residents and  
26 caregivers. The education and support shall include

1 referrals to support organizations for educational  
2 materials on community resources, support groups, legal  
3 and financial issues, respite care, and future care needs  
4 and options. The education and support shall also include  
5 a discussion of the resident's need to make advance  
6 directives and to identify surrogates for medical and  
7 legal decision-making. The provisions of this paragraph  
8 establish the minimum level of services that must be  
9 provided by an Alzheimer's disease management center. An  
10 Alzheimer's disease management center model shall have no  
11 more than 100 residents. Nothing in this paragraph (5)  
12 shall be construed as prohibiting a person or facility  
13 from providing services and care to persons with  
14 Alzheimer's disease as otherwise authorized under State  
15 law.

16 (6) Alternative health care delivery model; birth  
17 center. A birth center shall be exclusively dedicated to  
18 serving the childbirth-related needs of women and their  
19 newborns and shall have no more than 10 beds. A birth  
20 center is a designated site that is away from the mother's  
21 usual place of residence and in which births are planned  
22 to occur following a normal, uncomplicated, and low-risk  
23 pregnancy. A birth center shall offer prenatal care and  
24 community education services and shall coordinate these  
25 services with other health care services available in the  
26 community.

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

3 (1) A part of a hospital; or

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

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

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

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

18 In adopting rules for birth centers, the Department  
19 shall consider: the American Association of Birth Centers'  
20 Standards for Freestanding Birth Centers; the American  
21 Academy of Pediatrics/American College of Obstetricians  
22 and Gynecologists Guidelines for Perinatal Care; and the  
23 Regionalized Perinatal Health Care Code. The Department's  
24 rules shall stipulate the eligibility criteria for birth  
25 center admission. The Department's rules shall stipulate  
26 the necessary equipment for emergency care according to

1 the American Association of Birth Centers' standards and  
2 any additional equipment deemed necessary by the  
3 Department. The Department's rules shall provide for a  
4 time period within which each birth center not part of a  
5 hospital must become accredited by either the Commission  
6 for the Accreditation of Freestanding Birth Centers or The  
7 Joint Commission.

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

16 A birth center that is not operated under a hospital  
17 license shall be located within a ground travel time  
18 distance from the general acute care hospital with which  
19 the birth center maintains a contractual relationship,  
20 including a transfer agreement, as required under this  
21 paragraph, that allows for an emergency caesarian delivery  
22 to be started within 30 minutes of the decision a  
23 caesarian delivery is necessary. A birth center operating  
24 under a hospital license shall be located within a ground  
25 travel time distance from the licensed hospital that  
26 allows for an emergency caesarian delivery to be started

1           within 30 minutes of the decision a caesarian delivery is  
2           necessary.

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

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

26          An obstetrician, family practitioner, or certified

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

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

16 A birth center shall participate in the Illinois  
17 Perinatal System under the Developmental Disability  
18 Prevention Act. At a minimum, this participation shall  
19 require a birth center to establish a letter of agreement  
20 with a hospital designated under the Perinatal System. A  
21 hospital that operates or has a letter of agreement with a  
22 birth center shall include the birth center under its  
23 maternity service plan under the Hospital Licensing Act  
24 and shall include the birth center in the hospital's  
25 letter of agreement with its regional perinatal center.

26 A birth center may not discriminate against any

1 patient requiring treatment because of the source of  
2 payment for services, including Medicare and Medicaid  
3 recipients.

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

- 11 (i) Birth center ownership.
- 12 (ii) Sources of payment for services.
- 13 (iii) Utilization data involving patient length of  
14 stay.
- 15 (iv) Admissions and discharges.
- 16 (v) Complications.
- 17 (vi) Transfers.
- 18 (vii) Unusual incidents.
- 19 (viii) Deaths.
- 20 (ix) Any other publicly reported data required  
21 under the Illinois Consumer Guide.
- 22 (x) Post-discharge patient status data where  
23 patients are followed for 14 days after discharge from  
24 the birth center to determine whether the mother or  
25 baby developed a complication or infection.
- 26 Within 9 months after the effective date of this

1           amendatory Act of the 95th General Assembly, the  
2           Department shall adopt rules that are developed with  
3           consideration of: the American Association of Birth  
4           Centers' Standards for Freestanding Birth Centers; the  
5           American Academy of Pediatrics/American College of  
6           Obstetricians and Gynecologists Guidelines for Perinatal  
7           Care; and the Regionalized Perinatal Health Care Code.

8           The Department shall adopt other rules as necessary to  
9           implement the provisions of this amendatory Act of the  
10          95th General Assembly within 9 months after the effective  
11          date of this amendatory Act of the 95th General Assembly.

12         (Source: P.A. 100-518, eff. 12-8-17 (see Section 5 of P.A.  
13         100-558 for the effective date of changes made by P.A.  
14         100-518).)

15          Section 2-105. The Home Health, Home Services, and Home  
16          Nursing Agency Licensing Act is amended by changing Section  
17          2.11 and by adding Section 2.13 as follows:

18                 (210 ILCS 55/2.11)

19          Sec. 2.11. "Home nursing agency" means an agency that  
20          provides services directly, or acts as a placement agency, in  
21          order to deliver skilled nursing and home health aide services  
22          to persons in their personal residences or a certified family  
23          health aide, as defined by the Certified Family Health Aide  
24          Program for Children and Adults Act, for individuals receiving

1 or eligible to receive: (1) in-home shift nursing services  
2 under the Early and Periodic Screening, Diagnostic and  
3 Treatment requirement of Medicaid under 42 U.S.C. 1396d(r); or  
4 (2) in-home shift nursing services through the home and  
5 community-based services waiver program authorized under  
6 Section 1915(c) of the Social Security Act for persons who are  
7 medically fragile and technology dependent. A home nursing  
8 agency provides services that would require a licensed nurse  
9 to perform. Home health aide services are provided under the  
10 direction of a registered professional nurse or advanced  
11 practice registered nurse. A home nursing agency does not  
12 require licensure as a home health agency under this Act.  
13 "Home nursing agency" does not include an individually  
14 licensed nurse acting as a private contractor or a person that  
15 provides or procures temporary employment in health care  
16 facilities, as defined in the Nurse Agency Licensing Act.

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

18 (210 ILCS 55/2.13 new)

19 Sec. 2.13. Certified family health aide. A home nursing  
20 agency may provide initial and ongoing training for, and shall  
21 keep records in a manner designated by the Department  
22 regarding, the certified family health aide, as defined in the  
23 Certified Family Health Aide Program for Children and Adults  
24 Act, identified as the legally responsible caregiver or  
25 designated by the legally responsible caregiver for an

1 individual who receives or is eligible to receive:

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

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

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

11 (210 ILCS 85/17 new)

12 Sec. 17. Certified family health aide. Hospitals managing  
13 the care of an individual to be discharged under the care of a  
14 home nursing agency may provide initial training, and shall  
15 document in a manner designated by the Department, for the  
16 certified family health aide, as defined in the Certified  
17 Family Health Aide Program for Children and Adults Act,  
18 identified as the legally responsible caregiver or designated  
19 by a legally responsible caregiver for an individual who  
20 receives or is eligible to receive: (1) in-home shift nursing  
21 services under the Early and Periodic Screening, Diagnostic  
22 and Treatment requirement of Medicaid under 42 U.S.C. 1396d(r)  
23 or (2) in-home shift nursing through the home and  
24 community-based services waiver program authorized under

1 Section 1915(c) of the Social Security Act for persons who are  
2 medically fragile and technology dependent.

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

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

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

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

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

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

20 (1) The practice of nursing in Federal employment in  
21 the discharge of the employee's duties by a person who is  
22 employed by the United States government or any bureau,  
23 division or agency thereof and is a legally qualified and  
24 licensed nurse of another state or territory and not in

1 conflict with Sections 50-50, 55-10, 60-10, and 70-5 of  
2 this Act.

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

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

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

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

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

18 (7) The practice of practical nursing by one who is a  
19 licensed practical nurse under the laws of another U.S.  
20 jurisdiction and has applied in writing to the Department,  
21 in form and substance satisfactory to the Department, for  
22 a license as a licensed practical nurse and who is  
23 qualified to receive such license under this Act, until  
24 (i) the expiration of 6 months after the filing of such  
25 written application, (ii) the withdrawal of such  
26 application, or (iii) the denial of such application by

1 the Department.

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

13 (9) The practice of professional nursing by one who is  
14 a registered professional nurse under the laws of another  
15 United States jurisdiction or a foreign jurisdiction and  
16 has applied in writing to the Department, in form and  
17 substance satisfactory to the Department, for a license as  
18 a registered professional nurse and who is qualified to  
19 receive such license under Section 55-10, until (1) the  
20 expiration of 6 months after the filing of such written  
21 application, (2) the withdrawal of such application, or  
22 (3) the denial of such application by the Department.

23 (10) The practice of professional nursing that is  
24 included in a program of study by one who is a registered  
25 professional nurse under the laws of another United States  
26 jurisdiction or a foreign jurisdiction and who is enrolled

1 in a graduate nursing education program or a program for  
2 the completion of a baccalaureate nursing degree in this  
3 State, which includes clinical supervision by faculty as  
4 determined by the educational institution offering the  
5 program and the health care organization where the  
6 practice of nursing occurs.

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

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

14 (13) (Blank).

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

18 (15) The practice of relevant care by a legally  
19 responsible caregiver or a person designated by a legally  
20 responsible caregiver who has been certified as a  
21 certified family health aide, as defined in the Certified  
22 Family Health Aide Program for Children and Adults Act, to  
23 perform for a person who receives or is eligible to  
24 receive: (i) in-home shift nursing services under the  
25 Early and Periodic Screening, Diagnostic and Treatment  
26 requirement of Medicaid under 42 U.S.C. 1396d(r); or (ii)

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

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

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

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

12       (305 ILCS 5/5-2.06b new)

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

15       (a) The Department of Healthcare and Family Services may  
16       seek any federal approval from the Centers for Medicare and  
17       Medicaid Services necessary to reimburse a legally responsible  
18       caregiver or a person designated by a legally responsible  
19       caregiver, as defined in the Certified Family Health Aide  
20       Program for Children and Adults Act, who has achieved  
21       certification as a certified family health aide to perform or  
22       assist in performance of services for a person who receives or  
23       is eligible to receive: (1) in-home shift nursing services  
24       under the Early and Periodic Screening, Diagnostic and

1 Treatment requirement of Medicaid under 42 U.S.C. 1396d(r); or  
2 (2) the home and community-based services waiver program  
3 authorized under Section 1915(c) of the Social Security Act  
4 for a designated person or designated persons who are  
5 medically fragile and technology dependent. Implementation of  
6 any and all parts of the certified family health aide program  
7 is subject to the Department of Healthcare and Family Services  
8 receiving all necessary federal approval. If the Department of  
9 Healthcare and Family Services receives all necessary federal  
10 approval the Department may adopt rules in consultation with  
11 the Department of Public Health to specify the federally  
12 approved services eligible for reimbursement under the  
13 certified family health aide certification and to adopt any  
14 other policies or procedures necessary to implement this  
15 Section.

16 (b) The Department of Healthcare and Family Services, in  
17 partnership with the Department of Public Health, may consult  
18 with stakeholders for expertise regarding implementation of  
19 the certified family health aide program. Stakeholders may  
20 include, the University of Illinois at Chicago, Division of  
21 Specialized Care for Children, home nurse agencies, a  
22 physician with medical experience with the population being  
23 served by the program, children's hospitals, a legally  
24 responsible caregiver as described in item (3) of Section 10  
25 of the Certified Family Health Aide Program for Children and  
26 Adults Act, and a Children's Community-Based Health Care

1 Clinic.

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

16 ARTICLE 5.

17 Section 5-5. The Illinois Public Aid Code is amended by  
18 adding Sections 5-18.6 and 5-18.7 as follows:

19 (305 ILCS 5/5-18.6 new)

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

22 (a) Recognizing the importance that doulas provide in the  
23 support and advocacy for pregnant persons, within 6 months

1 after this amendatory Act of the 104th General Assembly, all  
2 hospitals with licensed obstetric beds and birthing centers  
3 shall adopt and maintain written policies and procedures to  
4 permit a patient enrolled in the medical assistance program to  
5 have an Illinois Medicaid certified and enrolled doula of the  
6 patient's choice accompany the patient within the facility's  
7 premises for the purposes of providing support before, during,  
8 and after labor and childbirth.

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

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

18 (b) Nothing in this Section shall be construed to provide  
19 a doula with access to a patient when that access is  
20 inconsistent with generally accepted medical standards or  
21 practices.

22 (c) Nothing in this Section is intended to expand or limit  
23 the malpractice liability of a hospital beyond the limits  
24 existing in current Illinois statutory and common law;  
25 however, no hospital shall be liable for any act or omission  
26 resulting from the provision of services by any doula solely

1 on the basis that the hospital permitted an Illinois Medicaid  
2 certified and enrolled doula of the patient's choice to  
3 accompany the patient within the facility's premises for the  
4 purposes of providing support before, during, and after labor  
5 and childbirth. The hospital and Illinois Medicaid certified  
6 and enrolled doula providing care are responsible for their  
7 own acts and omissions.

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

12 (305 ILCS 5/5-18.7 new)

13 Sec. 5-18.7. Standing recommendations. The Department of  
14 Healthcare and Family Services and the Department of Public  
15 Health may establish standing recommendations to meet Centers  
16 for Medicare and Medicaid Services requirements and ensure  
17 access to preventive services, including Medicaid-covered  
18 maternal and reproductive health supports and services, such  
19 as, but not limited to, doulas, lactation consultants, home  
20 visitors, community health workers, and 1115 Waiver services.  
21 No employee of the Department of Healthcare and Family  
22 Services or the Department of Public Health issuing a standing  
23 recommendation in accordance with this Section shall, as a  
24 result of the employee's acts or omissions in issuing the  
25 standing recommendation, be subject to (i) any disciplinary or

1 other adverse action under the Medical Practice Act of 1987,  
2 (ii) any civil liability, or (iii) any criminal liability.

3 ARTICLE 10.

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

6 (305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

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

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

16 2. Beginning January 1, 2014, persons otherwise  
17 eligible for basic maintenance under Article III,  
18 excluding any eligibility requirements that are  
19 inconsistent with any federal law or federal regulation,  
20 as interpreted by the U.S. Department of Health and Human  
21 Services, but who fail to qualify thereunder on the basis  
22 of need, and who have insufficient income and resources to  
23 meet the costs of necessary medical care, including, but

1 not limited to, the following:

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

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

10 (ii) their income, after the deduction of  
11 costs incurred for medical care and for other  
12 types of remedial care, is equal to or less than  
13 100% of the federal poverty level.

14 (b) (Blank).

15 3. (Blank).

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

21 5.(a) Beginning January 1, 2020, individuals during  
22 pregnancy and during the 12-month period beginning on the  
23 last day of the pregnancy, together with their infants,  
24 whose income is at or below 200% of the federal poverty  
25 level. Until September 30, 2019, or sooner if the  
26 maintenance of effort requirements under the Patient

1 Protection and Affordable Care Act are eliminated or may  
2 be waived before then, individuals during pregnancy and  
3 during the 12-month period beginning on the last day of  
4 the pregnancy, whose countable monthly income, after the  
5 deduction of costs incurred for medical care and for other  
6 types of remedial care as specified in administrative  
7 rule, is equal to or less than the Medical Assistance-No  
8 Grant(C) (MANG(C)) Income Standard in effect on April 1,  
9 2013 as set forth in administrative rule.

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

17 (c) The Illinois Department may conduct a  
18 demonstration in at least one county that will provide  
19 medical assistance to pregnant individuals together with  
20 their infants and children up to one year of age, where the  
21 income eligibility standard is set up to 185% of the  
22 nonfarm income official poverty line, as defined by the  
23 federal Office of Management and Budget. The Illinois  
24 Department shall seek and obtain necessary authorization  
25 provided under federal law to implement such a  
26 demonstration. Such demonstration may establish resource

1 standards that are not more restrictive than those  
2 established under Article IV of this Code.

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

19 (b) Children and youth who are under temporary custody  
20 or guardianship of the Department of Children and Family  
21 Services or who receive financial assistance in support of  
22 an adoption or guardianship placement from the Department  
23 of Children and Family Services.

24 7. (Blank).

25 8. As required under federal law, persons who are  
26 eligible for Transitional Medical Assistance as a result

1 of an increase in earnings or child or spousal support  
2 received. The plan for coverage for this class of persons  
3 shall:

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

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

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

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

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

16 (iv) such coverage shall be suspended in the  
17 event of a person's failure without good cause to  
18 file in a timely fashion reports required for this  
19 coverage under the Social Security Act and  
20 coverage shall be reinstated upon the filing of  
21 such reports if the person remains otherwise  
22 eligible.

23 9. Persons with acquired immunodeficiency syndrome  
24 (AIDS) or with AIDS-related conditions with respect to  
25 whom there has been a determination that but for home or  
26 community-based services such individuals would require

1 the level of care provided in an inpatient hospital,  
2 skilled nursing facility or intermediate care facility the  
3 cost of which is reimbursed under this Article. Assistance  
4 shall be provided to such persons to the maximum extent  
5 permitted under Title XIX of the Federal Social Security  
6 Act.

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

12 11. Persons with disabilities who are employed and  
13 eligible for Medicaid, pursuant to Section  
14 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and,  
15 subject to federal approval, persons with a medically  
16 improved disability who are employed and eligible for  
17 Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of  
18 the Social Security Act, as provided by the Illinois  
19 Department by rule. In establishing eligibility standards  
20 under this paragraph 11, the Department shall, subject to  
21 federal approval:

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

24 (b) exempt retirement accounts that the person  
25 cannot access without penalty before the age of 59  
26 1/2, and medical savings accounts established pursuant

1 to 26 U.S.C. 220;

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

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

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

15 (1) persons who have been screened for breast or  
16 cervical cancer under the U.S. Centers for Disease  
17 Control and Prevention Breast and Cervical Cancer  
18 Program established under Title XV of the federal  
19 Public Health Service Act in accordance with the  
20 requirements of Section 1504 of that Act as  
21 administered by the Illinois Department of Public  
22 Health; and

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

1           "Medical assistance" under this paragraph 12 shall be  
2 identical to the benefits provided under the State's  
3 approved plan under Title XIX of the Social Security Act.  
4 The Department must request federal approval of the  
5 coverage under this paragraph 12 within 30 days after July  
6 3, 2001 (the effective date of Public Act 92-47).

7           In addition to the persons who are eligible for  
8 medical assistance pursuant to subparagraphs (1) and (2)  
9 of this paragraph 12, and to be paid from funds  
10 appropriated to the Department for its medical programs,  
11 any uninsured person as defined by the Department in rules  
12 residing in Illinois who is younger than 65 years of age,  
13 who has been screened for breast and cervical cancer in  
14 accordance with standards and procedures adopted by the  
15 Department of Public Health for screening, and who is  
16 referred to the Department by the Department of Public  
17 Health as being in need of treatment for breast or  
18 cervical cancer is eligible for medical assistance  
19 benefits that are consistent with the benefits provided to  
20 those persons described in subparagraphs (1) and (2).  
21 Medical assistance coverage for the persons who are  
22 eligible under the preceding sentence is not dependent on  
23 federal approval, but federal moneys may be used to pay  
24 for services provided under that coverage upon federal  
25 approval.

26           13. Subject to appropriation and to federal approval,

1 persons living with HIV/AIDS who are not otherwise  
2 eligible under this Article and who qualify for services  
3 covered under Section 5-5.04 as provided by the Illinois  
4 Department by rule.

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

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

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

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

13 (d) meet one of the following conditions:

14 (i) have filed an application for asylum  
15 status under 8 U.S.C. 1158 that is pending with  
16 the appropriate federal agency or have a pending  
17 appeal of such an application ~~pending before the~~  
18 ~~federal Department of Homeland Security or on~~  
19 ~~appeal~~ before a court of competent jurisdiction  
20 and are represented either by counsel or by an  
21 advocate accredited by the appropriate federal  
22 agency ~~Department of Homeland Security~~ and  
23 employed by a not-for-profit organization in  
24 regard to that application or appeal; ~~or~~

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

1           (iii) have filed a pending application for T  
2           nonimmigrant status pursuant to 8 U.S.C.  
3           1101(a)(15)(T);

4           (iv) have filed a pending application for U  
5           nonimmigrant status pursuant to 8 U.S.C.  
6           1101(a)(15)(U); or

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

10           Medical coverage under this paragraph 14 may be  
11           provided for up to 24 continuous months from the initial  
12           eligibility date so long as an individual continues to  
13           satisfy the criteria of this paragraph 14. If an  
14           individual has an application or appeal pending regarding  
15           an application for asylum, T nonimmigrant status, or U  
16           nonimmigrant status before the appropriate federal agency  
17           for such applications or appeals ~~Department of Homeland~~  
18           ~~Security~~, eligibility under this paragraph 14 may be  
19           extended until a final decision is rendered with respect  
20           to the application or appeal, except that an individual  
21           who is approved for a U visa continues to qualify for  
22           medical coverage under this paragraph 14 as long as the  
23           individual meets all other eligibility criteria ~~on the~~  
24           ~~appeal~~. The Department shall ~~may~~ adopt rules governing the  
25           implementation of this paragraph 14.

26           15. Family Care Eligibility.

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

6           (b) Eligibility shall be reviewed annually.

7           (c) (Blank).

8           (d) (Blank).

9           (e) (Blank).

10          (f) (Blank).

11          (g) (Blank).

12          (h) (Blank).

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

17          16. Subject to appropriation, uninsured persons who  
18          are not otherwise eligible under this Section who have  
19          been certified and referred by the Department of Public  
20          Health as having been screened and found to need  
21          diagnostic evaluation or treatment, or both diagnostic  
22          evaluation and treatment, for prostate or testicular  
23          cancer. For the purposes of this paragraph 16, uninsured  
24          persons are those who do not have creditable coverage, as  
25          defined under the Health Insurance Portability and  
26          Accountability Act, or have otherwise exhausted any

1 insurance benefits they may have had, for prostate or  
2 testicular cancer diagnostic evaluation or treatment, or  
3 both diagnostic evaluation and treatment. To be eligible,  
4 a person must furnish a Social Security number. A person's  
5 assets are exempt from consideration in determining  
6 eligibility under this paragraph 16. Such persons shall be  
7 eligible for medical assistance under this paragraph 16  
8 for so long as they need treatment for the cancer. A person  
9 shall be considered to need treatment if, in the opinion  
10 of the person's treating physician, the person requires  
11 therapy directed toward cure or palliation of prostate or  
12 testicular cancer, including recurrent metastatic cancer  
13 that is a known or presumed complication of prostate or  
14 testicular cancer and complications resulting from the  
15 treatment modalities themselves. Persons who require only  
16 routine monitoring services are not considered to need  
17 treatment. "Medical assistance" under this paragraph 16  
18 shall be identical to the benefits provided under the  
19 State's approved plan under Title XIX of the Social  
20 Security Act. Notwithstanding any other provision of law,  
21 the Department (i) does not have a claim against the  
22 estate of a deceased recipient of services under this  
23 paragraph 16 and (ii) does not have a lien against any  
24 homestead property or other legal or equitable real  
25 property interest owned by a recipient of services under  
26 this paragraph 16.

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

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

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

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

17           18. Beginning January 1, 2014, persons aged 19 or  
18 older, but younger than 65, who are not otherwise eligible  
19 for medical assistance under this Section 5-2, who qualify  
20 for medical assistance pursuant to 42 U.S.C.  
21 1396a(a)(10)(A)(i)(VIII) and applicable federal  
22 regulations, and who have income at or below 133% of the  
23 federal poverty level plus 5% for the applicable family  
24 size as determined pursuant to 42 U.S.C. 1396a(e)(14) and  
25 applicable federal regulations. Persons eligible for  
26 medical assistance under this paragraph 18 shall receive

1 coverage for the Health Benefits Service Package as that  
2 term is defined in subsection (m) of Section 5-1.1 of this  
3 Code. If Illinois' federal medical assistance percentage  
4 (FMAP) is reduced below 90% for persons eligible for  
5 medical assistance under this paragraph 18, eligibility  
6 under this paragraph 18 shall cease no later than the end  
7 of the third month following the month in which the  
8 reduction in FMAP takes effect.

9 19. Beginning January 1, 2014, as required under 42  
10 U.S.C. 1396a(a)(10)(A)(i)(IX), persons older than age 18  
11 and younger than age 26 who are not otherwise eligible for  
12 medical assistance under paragraphs (1) through (17) of  
13 this Section who (i) were in foster care under the  
14 responsibility of the State on the date of attaining age  
15 18 or on the date of attaining age 21 when a court has  
16 continued wardship for good cause as provided in Section  
17 2-31 of the Juvenile Court Act of 1987 and (ii) received  
18 medical assistance under the Illinois Title XIX State Plan  
19 or waiver of such plan while in foster care.

20 20. (Blank). ~~Beginning January 1, 2018, persons who~~  
21 ~~are foreign born victims of human trafficking, torture, or~~  
22 ~~other serious crimes as defined in Section 2-19 of this~~  
23 ~~Code and their derivative family members if such persons:~~  
24 ~~(i) reside in Illinois; (ii) are not eligible under any of~~  
25 ~~the preceding paragraphs; (iii) meet the income guidelines~~  
26 ~~of subparagraph (a) of paragraph 2; and (iv) meet the~~

1 ~~nonfinancial eligibility requirements of Sections 16-2,~~  
2 ~~16-3, and 16-5 of this Code. The Department may extend~~  
3 ~~medical assistance for persons who are foreign-born~~  
4 ~~victims of human trafficking, torture, or other serious~~  
5 ~~crimes whose medical assistance would be terminated~~  
6 ~~pursuant to subsection (b) of Section 16-5 if the~~  
7 ~~Department determines that the person, during the year of~~  
8 ~~initial eligibility (1) experienced a health crisis, (2)~~  
9 ~~has been unable, after reasonable attempts, to obtain~~  
10 ~~necessary information from a third party, or (3) has other~~  
11 ~~extenuating circumstances that prevented the person from~~  
12 ~~completing his or her application for status. The~~  
13 ~~Department may adopt any rules necessary to implement the~~  
14 ~~provisions of this paragraph.~~

15 21. Persons who are not otherwise eligible for medical  
16 assistance under this Section who may qualify for medical  
17 assistance pursuant to 42 U.S.C.  
18 1396a(a)(10)(A)(ii)(XXIII) and 42 U.S.C. 1396(ss) for the  
19 duration of any federal or State declared emergency due to  
20 COVID-19. Medical assistance to persons eligible for  
21 medical assistance solely pursuant to this paragraph 21  
22 shall be limited to any in vitro diagnostic product (and  
23 the administration of such product) described in 42 U.S.C.  
24 1396d(a)(3)(B) on or after March 18, 2020, any visit  
25 described in 42 U.S.C. 1396o(a)(2)(G), or any other  
26 medical assistance that may be federally authorized for

1           this class of persons. The Department may also cover  
2           treatment of COVID-19 for this class of persons, or any  
3           similar category of uninsured individuals, to the extent  
4           authorized under a federally approved 1115 Waiver or other  
5           federal authority. Notwithstanding the provisions of  
6           Section 1-11 of this Code, due to the nature of the  
7           COVID-19 public health emergency, the Department may cover  
8           and provide the medical assistance described in this  
9           paragraph 21 to noncitizens who would otherwise meet the  
10          eligibility requirements for the class of persons  
11          described in this paragraph 21 for the duration of the  
12          State emergency period.

13          In implementing the provisions of Public Act 96-20, the  
14          Department is authorized to adopt only those rules necessary,  
15          including emergency rules. Nothing in Public Act 96-20 permits  
16          the Department to adopt rules or issue a decision that expands  
17          eligibility for the FamilyCare Program to a person whose  
18          income exceeds 185% of the Federal Poverty Level as determined  
19          from time to time by the U.S. Department of Health and Human  
20          Services, unless the Department is provided with express  
21          statutory authority.

22          The eligibility of any such person for medical assistance  
23          under this Article is not affected by the payment of any grant  
24          under the Senior Citizens and Persons with Disabilities  
25          Property Tax Relief Act or any distributions or items of  
26          income described under subparagraph (X) of paragraph (2) of

1 subsection (a) of Section 203 of the Illinois Income Tax Act.

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

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

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

21 Notwithstanding any other provision of this Code, if the  
22 United States Supreme Court holds Title II, Subtitle A,  
23 Section 2001(a) of Public Law 111-148 to be unconstitutional,  
24 or if a holding of Public Law 111-148 makes Medicaid  
25 eligibility allowed under Section 2001(a) inoperable, the  
26 State or a unit of local government shall be prohibited from

1 enrolling individuals in the Medical Assistance Program as the  
2 result of federal approval of a State Medicaid waiver on or  
3 after June 14, 2012 (the effective date of Public Act 97-687),  
4 and any individuals enrolled in the Medical Assistance Program  
5 pursuant to eligibility permitted as a result of such a State  
6 Medicaid waiver shall become immediately ineligible.

7 Notwithstanding any other provision of this Code, if an  
8 Act of Congress that becomes a Public Law eliminates Section  
9 2001(a) of Public Law 111-148, the State or a unit of local  
10 government shall be prohibited from enrolling individuals in  
11 the Medical Assistance Program as the result of federal  
12 approval of a State Medicaid waiver on or after June 14, 2012  
13 (the effective date of Public Act 97-687), and any individuals  
14 enrolled in the Medical Assistance Program pursuant to  
15 eligibility permitted as a result of such a State Medicaid  
16 waiver shall become immediately ineligible.

17 Effective October 1, 2013, the determination of  
18 eligibility of persons who qualify under paragraphs 5, 6, 8,  
19 15, 17, and 18 of this Section shall comply with the  
20 requirements of 42 U.S.C. 1396a(e)(14) and applicable federal  
21 regulations.

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

1 health insurance coverage.

2 (Source: P.A. 101-10, eff. 6-5-19; 101-649, eff. 7-7-20;  
3 102-43, eff. 7-6-21; 102-558, eff. 8-20-21; 102-665, eff.  
4 10-8-21; 102-813, eff. 5-13-22.)

5 ARTICLE 15.

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

8 (305 ILCS 5/5-5.09a new)

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

10 (a) Notwithstanding any other provisions of law, the  
11 Department of Healthcare and Family Services shall develop, in  
12 collaboration with the Department of Human Services and the  
13 Department of Public Health, recommended screening guidelines  
14 for tardive dyskinesia for providers serving patients  
15 prescribed antipsychotic medications under the medical  
16 assistance program in State-operated residential facilities  
17 and community-based settings.

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

23 (c) The Department of Healthcare and Family Services and

1 the Department of Human Services, in collaboration with the  
2 Department of Public Health, shall develop communication  
3 strategies and educational materials to be offered to health  
4 care providers regarding tardive dyskinesia, the recommended  
5 screening guidelines, and any subsequent revisions. In  
6 developing the information to be disseminated under this  
7 Section, the Departments of Healthcare and Family Services,  
8 Human Services, and Public Health shall consult with a  
9 statewide association representing physicians licensed to  
10 practice medicine in all its branches and a statewide  
11 association representing psychiatrists.

12 ARTICLE 20.

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

15 (305 ILCS 5/5-5.12f)

16 Sec. 5-5.12f. Prescription drugs for mental illness; no  
17 utilization or prior approval mandates.

18 (a) Notwithstanding any other provision of this Code to  
19 the contrary, except as otherwise provided in subsection (b),  
20 for the purpose of removing barriers to the timely treatment  
21 of serious mental illnesses, prior authorization mandates and  
22 utilization management controls shall not be imposed under the  
23 fee-for-service and managed care medical assistance programs

1 on any FDA-approved prescription drug that is recognized by a  
2 generally accepted standard medical reference as effective in  
3 the treatment of conditions specified in the most recent  
4 Diagnostic and Statistical Manual of Mental Disorders  
5 published by the American Psychiatric Association if a  
6 preferred or non-preferred drug is prescribed to an adult  
7 patient to treat serious mental illness and one of the  
8 following applies:

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

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

19 (3) subject to federal law on maximum dosage limits  
20 and safety edits adopted by the Department's Drug and  
21 Therapeutics Board, including those safety edits and  
22 limits needed to comply with federal requirements  
23 contained in 42 CFR 456.703, the patient has previously  
24 been prescribed and obtained prior authorization for the  
25 drug and the prescription modifies the dosage, dosage  
26 frequency, or both, of the drug as part of the same

1 treatment for which the drug was previously prescribed.

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

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

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

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

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

19 (1) Delusional Disorder (F22)

20 (2) Brief Psychotic Disorder (F23)

21 (3) Schizophreniform Disorder (F20.81)

22 (4) Schizophrenia (F20.9)

23 (5) Schizoaffective Disorder (F25.x)

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

26 (7) Other Specified Schizophrenia Spectrum and Other

1 Psychotic Disorder (F28)

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

4 (9) Bipolar I Disorder (F31.xx)

5 (10) Bipolar II Disorder (F31.81)

6 (11) Cyclothymic Disorder (F34.0)

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

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

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

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

12 (16) Obsessive-Compulsive Disorder (F42)

13 (17) Posttraumatic Stress Disorder (F43.10)

14 (18) Anorexia Nervosa (F50.0x)

15 (19) Bulimia Nervosa (F50.2)

16 (20) Postpartum Depression (F53.0)

17 (21) Puerperal Psychosis (F53.1)

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

19 (d) Notwithstanding any other provision of law, nothing in  
20 this Section shall not be construed to conflict with Section  
21 1927(a)(1) and (b)(1)(A) of the federal Social Security Act  
22 and any implementing regulations and agreements.

23 (e) The Department shall publish a report semi-annually on  
24 its website on compliance with the conditions of this Section  
25 by the fee-for-service program and managed care organizations  
26 beginning with dates of service on and after July 1, 2025.

1 These reports shall be due 12 months after the end of the  
2 period to be reported. These reports shall include:

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

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

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

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

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

19 (6) The number of persons enrolled in the medical  
20 assistance program using emergency room services based on  
21 categories specified in subsection (c) as the primary  
22 diagnosis for the emergency room visit.

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



1 with a disability, as defined under the federal Supplemental  
2 Security Income program and who are medically fragile and  
3 technology dependent. The program shall allow eligible  
4 children to receive the medical assistance provided under this  
5 Article in the community and must maximize, to the fullest  
6 extent permissible under federal law, federal reimbursement  
7 and family cost-sharing, including co-pays, premiums, or any  
8 other family contributions, except that the Department shall  
9 be permitted to incentivize the utilization of selected  
10 services through the use of cost-sharing adjustments. The  
11 Department shall establish the policies, procedures,  
12 standards, services, and criteria for this program by rule.

13 (b) Notwithstanding any other provision of this Code,  
14 subject to federal approval, on and after January 1, 2024, the  
15 reimbursement rates for nursing paid through Nursing and  
16 Personal Care Services for non-waiver customers and to  
17 providers of private duty nursing services for children  
18 eligible for medical assistance under this Section shall be  
19 20% higher than the reimbursement rates in effect for nursing  
20 services on December 31, 2023.

21 (c) Notwithstanding any other provision of this Code,  
22 subject to federal approval, on and after January 1, 2025, the  
23 reimbursement rates for nursing paid through Nursing and  
24 Personal Care Services for non-waiver customers and to  
25 providers of private duty nursing services for children  
26 eligible for medical assistance under this Section shall be 7%

1 higher than the reimbursement rates in effect for nursing  
2 services on December 31, 2024.

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

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

22 ARTICLE 35.

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

1 (305 ILCS 5/5-65 new)

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

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

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

18 ARTICLE 40.

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

21 (305 ILCS 5/5-5)

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

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

1 disorders or co-occurring mental health and substance use  
2 disorders is determined using a uniform screening, assessment,  
3 and evaluation process inclusive of criteria, for children and  
4 adults; for purposes of this item (13), a uniform screening,  
5 assessment, and evaluation process refers to a process that  
6 includes an appropriate evaluation and, as warranted, a  
7 referral; "uniform" does not mean the use of a singular  
8 instrument, tool, or process that all must utilize; (14)  
9 transportation and such other expenses as may be necessary;  
10 (15) medical treatment of sexual assault survivors, as defined  
11 in Section 1a of the Sexual Assault Survivors Emergency  
12 Treatment Act, for injuries sustained as a result of the  
13 sexual assault, including examinations and laboratory tests to  
14 discover evidence which may be used in criminal proceedings  
15 arising from the sexual assault; (16) the diagnosis and  
16 treatment of sickle cell anemia; (16.5) services performed by  
17 a chiropractic physician licensed under the Medical Practice  
18 Act of 1987 and acting within the scope of his or her license,  
19 including, but not limited to, chiropractic manipulative  
20 treatment; and (17) any other medical care, and any other type  
21 of remedial care recognized under the laws of this State. The  
22 term "any other type of remedial care" shall include nursing  
23 care and nursing home service for persons who rely on  
24 treatment by spiritual means alone through prayer for healing.

25 Notwithstanding any other provision of this Section, a  
26 comprehensive tobacco use cessation program that includes

1 purchasing prescription drugs or prescription medical devices  
2 approved by the Food and Drug Administration shall be covered  
3 under the medical assistance program under this Article for  
4 persons who are otherwise eligible for assistance under this  
5 Article.

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

11 Notwithstanding any other provision of this Section, all  
12 tobacco cessation medications approved by the United States  
13 Food and Drug Administration and all individual and group  
14 tobacco cessation counseling services and telephone-based  
15 counseling services and tobacco cessation medications provided  
16 through the Illinois Tobacco Quitline shall be covered under  
17 the medical assistance program for persons who are otherwise  
18 eligible for assistance under this Article. The Department  
19 shall comply with all federal requirements necessary to obtain  
20 federal financial participation, as specified in 42 CFR  
21 433.15(b)(7), for telephone-based counseling services provided  
22 through the Illinois Tobacco Quitline, including, but not  
23 limited to: (i) entering into a memorandum of understanding or  
24 interagency agreement with the Department of Public Health, as  
25 administrator of the Illinois Tobacco Quitline; and (ii)  
26 developing a cost allocation plan for Medicaid-allowable

1 Illinois Tobacco Quitline services in accordance with 45 CFR  
2 95.507. The Department shall submit the memorandum of  
3 understanding or interagency agreement, the cost allocation  
4 plan, and all other necessary documentation to the Centers for  
5 Medicare and Medicaid Services for review and approval.  
6 Coverage under this paragraph shall be contingent upon federal  
7 approval.

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

15 Upon receipt of federal approval of an amendment to the  
16 Illinois Title XIX State Plan for this purpose, the Department  
17 shall authorize the Chicago Public Schools (CPS) to procure a  
18 vendor or vendors to manufacture eyeglasses for individuals  
19 enrolled in a school within the CPS system. CPS shall ensure  
20 that its vendor or vendors are enrolled as providers in the  
21 medical assistance program and in any capitated Medicaid  
22 managed care entity (MCE) serving individuals enrolled in a  
23 school within the CPS system. Under any contract procured  
24 under this provision, the vendor or vendors must serve only  
25 individuals enrolled in a school within the CPS system. Claims  
26 for services provided by CPS's vendor or vendors to recipients

1 of benefits in the medical assistance program under this Code,  
2 the Children's Health Insurance Program, or the Covering ALL  
3 KIDS Health Insurance Program shall be submitted to the  
4 Department or the MCE in which the individual is enrolled for  
5 payment and shall be reimbursed at the Department's or the  
6 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

18 On and after July 1, 2018, the Department of Healthcare  
19 and Family Services shall provide dental services to any adult  
20 who is otherwise eligible for assistance under the medical  
21 assistance program. As used in this paragraph, "dental  
22 services" means diagnostic, preventative, restorative, or  
23 corrective procedures, including procedures and services for  
24 the prevention and treatment of periodontal disease and dental  
25 caries disease, provided by an individual who is licensed to  
26 practice dentistry or dental surgery or who is under the

1 supervision of a dentist in the practice of his or her  
2 profession.

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

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

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

1 include a public health clinic or Federally Qualified Health  
2 Center or other enrolled provider, as determined by the  
3 Department, through which dental services covered under this  
4 Section are performed. The Department shall establish a  
5 process for payment of claims for reimbursement for covered  
6 dental services rendered under this provision.

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

11 On and after January 1, 2022, the Department of Healthcare  
12 and Family Services shall administer and regulate a  
13 school-based dental program that allows for the out-of-office  
14 delivery of preventative dental services in a school setting  
15 to children under 19 years of age. The Department shall  
16 establish, by rule, guidelines for participation by providers  
17 and set requirements for follow-up referral care based on the  
18 requirements established in the Dental Office Reference Manual  
19 published by the Department that establishes the requirements  
20 for dentists participating in the All Kids Dental School  
21 Program. Every effort shall be made by the Department when  
22 developing the program requirements to consider the different  
23 geographic differences of both urban and rural areas of the  
24 State for initial treatment and necessary follow-up care. No  
25 provider shall be charged a fee by any unit of local government  
26 to participate in the school-based dental program administered

1 by the Department. Nothing in this paragraph shall be  
2 construed to limit or preempt a home rule unit's or school  
3 district's authority to establish, change, or administer a  
4 school-based dental program in addition to, or independent of,  
5 the school-based dental program administered by the  
6 Department.

7 The Illinois Department, by rule, may distinguish and  
8 classify the medical services to be provided only in  
9 accordance with the classes of persons designated in Section  
10 5-2.

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

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

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

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

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

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

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

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

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

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

5 For purposes of this Section:

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

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

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

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

24 If, at any time, the Secretary of the United States  
25 Department of Health and Human Services, or its successor  
26 agency, promulgates rules or regulations to be published in

1 the Federal Register or publishes a comment in the Federal  
2 Register or issues an opinion, guidance, or other action that  
3 would require the State, pursuant to any provision of the  
4 Patient Protection and Affordable Care Act (Public Law  
5 111-148), including, but not limited to, 42 U.S.C.  
6 18031(d)(3)(B) or any successor provision, to defray the cost  
7 of any coverage for breast tomosynthesis outlined in this  
8 paragraph, then the requirement that an insurer cover breast  
9 tomosynthesis is inoperative other than any such coverage  
10 authorized under Section 1902 of the Social Security Act, 42  
11 U.S.C. 1396a, and the State shall not assume any obligation  
12 for the cost of coverage for breast tomosynthesis set forth in  
13 this paragraph.

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

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

26 The Department shall convene an expert panel including

1 representatives of hospitals, free-standing mammography  
2 facilities, and doctors, including radiologists, to establish  
3 quality standards for mammography.

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

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

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

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

1 mammography. The Department shall work with experts in breast  
2 cancer outreach and patient navigation to optimize these  
3 reminders and shall establish a methodology for evaluating  
4 their effectiveness and modifying the methodology based on the  
5 evaluation.

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

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

26 The Department shall require all networks of care to

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

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

19 On or after July 1, 2022, individuals who are otherwise  
20 eligible for medical assistance under this Article shall  
21 receive coverage for perinatal depression screenings for the  
22 12-month period beginning on the last day of their pregnancy.  
23 Medical assistance coverage under this paragraph shall be  
24 conditioned on the use of a screening instrument approved by  
25 the Department.

26 Any medical or health care provider shall immediately

1 recommend, to any pregnant individual who is being provided  
2 prenatal services and is suspected of having a substance use  
3 disorder as defined in the Substance Use Disorder Act,  
4 referral to a local substance use disorder treatment program  
5 licensed by the Department of Human Services or to a licensed  
6 hospital which provides substance abuse treatment services.  
7 The Department of Healthcare and Family Services shall assure  
8 coverage for the cost of treatment of the drug abuse or  
9 addiction for pregnant recipients in accordance with the  
10 Illinois Medicaid Program in conjunction with the Department  
11 of Human Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 providers who are treating or serving persons eligible for  
2 Medical Assistance under this Article. All dispensers of  
3 medical services shall be required to maintain and retain  
4 business and professional records sufficient to fully and  
5 accurately document the nature, scope, details and receipt of  
6 the health care provided to persons eligible for medical  
7 assistance under this Code, in accordance with regulations  
8 promulgated by the Illinois Department. The rules and  
9 regulations shall require that proof of the receipt of  
10 prescription drugs, dentures, prosthetic devices and  
11 eyeglasses by eligible persons under this Section accompany  
12 each claim for reimbursement submitted by the dispenser of  
13 such medical services. No such claims for reimbursement shall  
14 be approved for payment by the Illinois Department without  
15 such proof of receipt, unless the Illinois Department shall  
16 have put into effect and shall be operating a system of  
17 post-payment audit and review which shall, on a sampling  
18 basis, be deemed adequate by the Illinois Department to assure  
19 that such drugs, dentures, prosthetic devices and eyeglasses  
20 for which payment is being made are actually being received by  
21 eligible recipients. Within 90 days after September 16, 1984  
22 (the effective date of Public Act 83-1439), the Illinois  
23 Department shall establish a current list of acquisition costs  
24 for all prosthetic devices and any other items recognized as  
25 medical equipment and supplies reimbursable under this Article  
26 and shall update such list on a quarterly basis, except that

1 the acquisition costs of all prescription drugs shall be  
2 updated no less frequently than every 30 days as required by  
3 Section 5-5.12.

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

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

26 The Illinois Department shall require all dispensers of

1 medical services, other than an individual practitioner or  
2 group of practitioners, desiring to participate in the Medical  
3 Assistance program established under this Article to disclose  
4 all financial, beneficial, ownership, equity, surety or other  
5 interests in any and all firms, corporations, partnerships,  
6 associations, business enterprises, joint ventures, agencies,  
7 institutions or other legal entities providing any form of  
8 health care services in this State under this Article.

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

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

26 The Department has the discretion to limit the conditional

1 enrollment period for vendors based upon the category of risk  
2 of the vendor.

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

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

25 To be eligible for payment consideration, a vendor's  
26 payment claim or bill, either as an initial claim or as a

1 resubmitted claim following prior rejection, must be received  
2 by the Illinois Department, or its fiscal intermediary, no  
3 later than 180 days after the latest date on the claim on which  
4 medical goods or services were provided, with the following  
5 exceptions:

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

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

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

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

22 For claims for services rendered during a period for which  
23 a recipient received retroactive eligibility, claims must be  
24 filed within 180 days after the Department determines the  
25 applicant is eligible. For claims for which the Illinois  
26 Department is not the primary payer, claims must be submitted

1 to the Illinois Department within 180 days after the final  
2 adjudication by the primary payer.

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

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

22 To the extent consistent with applicable information and  
23 privacy, security, and disclosure laws, State and federal  
24 agencies and departments shall provide the Illinois Department  
25 access to confidential and other information and data  
26 necessary to perform eligibility and payment verifications and

1 other Illinois Department functions. This includes, but is not  
2 limited to: information pertaining to licensure;  
3 certification; earnings; immigration status; citizenship; wage  
4 reporting; unearned and earned income; pension income;  
5 employment; supplemental security income; social security  
6 numbers; National Provider Identifier (NPI) numbers; the  
7 National Practitioner Data Bank (NPDB); program and agency  
8 exclusions; taxpayer identification numbers; tax delinquency;  
9 corporate information; and death records.

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

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

15           The Illinois Department shall establish policies,  
16 procedures, standards and criteria by rule for the  
17 acquisition, repair and replacement of orthotic and prosthetic  
18 devices and durable medical equipment. Such rules shall  
19 provide, but not be limited to, the following services: (1)  
20 immediate repair or replacement of such devices by recipients;  
21 and (2) rental, lease, purchase or lease-purchase of durable  
22 medical equipment in a cost-effective manner, taking into  
23 consideration the recipient's medical prognosis, the extent of  
24 the recipient's needs, and the requirements and costs for  
25 maintaining such equipment. Subject to prior approval, such  
26 rules shall enable a recipient to temporarily acquire and use

1 alternative or substitute devices or equipment pending repairs  
2 or replacements of any device or equipment previously  
3 authorized for such recipient by the Department.  
4 Notwithstanding any provision of Section 5-5f to the contrary,  
5 the Department may, by rule, exempt certain replacement  
6 wheelchair parts from prior approval and, for wheelchairs,  
7 wheelchair parts, wheelchair accessories, and related seating  
8 and positioning items, determine the wholesale price by  
9 methods other than actual acquisition costs.

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

18 In order to promote environmental responsibility, meet the  
19 needs of recipients and enrollees, and achieve significant  
20 cost savings, the Department, or a managed care organization  
21 under contract with the Department, may provide recipients or  
22 managed care enrollees who have a prescription or Certificate  
23 of Medical Necessity access to refurbished durable medical  
24 equipment under this Section (excluding prosthetic and  
25 orthotic devices as defined in the Orthotics, Prosthetics, and  
26 Pedorthics Practice Act and complex rehabilitation technology

1 products and associated services) through the State's  
2 assistive technology program's reutilization program, using  
3 staff with the Assistive Technology Professional (ATP)  
4 Certification if the refurbished durable medical equipment:  
5 (i) is available; (ii) is less expensive, including shipping  
6 costs, than new durable medical equipment of the same type;  
7 (iii) is able to withstand at least 3 years of use; (iv) is  
8 cleaned, disinfected, sterilized, and safe in accordance with  
9 federal Food and Drug Administration regulations and guidance  
10 governing the reprocessing of medical devices in health care  
11 settings; and (v) equally meets the needs of the recipient or  
12 enrollee. The reutilization program shall confirm that the  
13 recipient or enrollee is not already in receipt of the same or  
14 similar equipment from another service provider, and that the  
15 refurbished durable medical equipment equally meets the needs  
16 of the recipient or enrollee. Nothing in this paragraph shall  
17 be construed to limit recipient or enrollee choice to obtain  
18 new durable medical equipment or place any additional prior  
19 authorization conditions on enrollees of managed care  
20 organizations.

21 The Department shall execute, relative to the nursing home  
22 prescreening project, written inter-agency agreements with the  
23 Department of Human Services and the Department on Aging, to  
24 effect the following: (i) intake procedures and common  
25 eligibility criteria for those persons who are receiving  
26 non-institutional services; and (ii) the establishment and

1 development of non-institutional services in areas of the  
2 State where they are not currently available or are  
3 undeveloped; and (iii) notwithstanding any other provision of  
4 law, subject to federal approval, on and after July 1, 2012, an  
5 increase in the determination of need (DON) scores from 29 to  
6 37 for applicants for institutional and home and  
7 community-based long term care; if and only if federal  
8 approval is not granted, the Department may, in conjunction  
9 with other affected agencies, implement utilization controls  
10 or changes in benefit packages to effectuate a similar savings  
11 amount for this population; and (iv) no later than July 1,  
12 2013, minimum level of care eligibility criteria for  
13 institutional and home and community-based long term care; and  
14 (v) no later than October 1, 2013, establish procedures to  
15 permit long term care providers access to eligibility scores  
16 for individuals with an admission date who are seeking or  
17 receiving services from the long term care provider. In order  
18 to select the minimum level of care eligibility criteria, the  
19 Governor shall establish a workgroup that includes affected  
20 agency representatives and stakeholders representing the  
21 institutional and home and community-based long term care  
22 interests. This Section shall not restrict the Department from  
23 implementing lower level of care eligibility criteria for  
24 community-based services in circumstances where federal  
25 approval has been granted.

26 The Illinois Department shall develop and operate, in

1 cooperation with other State Departments and agencies and in  
2 compliance with applicable federal laws and regulations,  
3 appropriate and effective systems of health care evaluation  
4 and programs for monitoring of utilization of health care  
5 services and facilities, as it affects persons eligible for  
6 medical assistance under this Code.

7 The Illinois Department shall report annually to the  
8 General Assembly, no later than the second Friday in April of  
9 1979 and each year thereafter, in regard to:

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

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

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

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

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

1 Library Act.

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

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

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

1 and the services under this Section shall be limited to  
2 services associated with kidney transplantation.

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

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

1 Department shall not impose a copayment on the coverage  
2 provided for naloxone hydrochloride under the medical  
3 assistance program.

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

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

24 Within 90 days after October 8, 2021 (the effective date  
25 of Public Act 102-665), the Department shall seek federal  
26 approval of a State Plan amendment to expand coverage for

1 family planning services that includes presumptive eligibility  
2 to individuals whose income is at or below 208% of the federal  
3 poverty level. Coverage under this Section shall be effective  
4 beginning no later than December 1, 2022.

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

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

21 Notwithstanding any other provision of this Code, within  
22 12 months after June 2, 2022 (the effective date of Public Act  
23 102-1037) and subject to federal approval, acupuncture  
24 services performed by an acupuncturist licensed under the  
25 Acupuncture Practice Act who is acting within the scope of his  
26 or her license shall be covered under the medical assistance

1 program. The Department shall apply for any federal waiver or  
2 State Plan amendment, if required, to implement this  
3 paragraph. The Department may adopt any rules, including  
4 standards and criteria, necessary to implement this paragraph.

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

23 Notwithstanding any other provision of this Code,  
24 beginning on January 1, 2024, subject to federal approval,  
25 cognitive assessment and care planning services provided to a  
26 person who experiences signs or symptoms of cognitive

1 impairment, as defined by the Diagnostic and Statistical  
2 Manual of Mental Disorders, Fifth Edition, shall be covered  
3 under the medical assistance program for persons who are  
4 otherwise eligible for medical assistance under this Article.

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

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

17 (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;  
18 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article  
19 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,  
20 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;  
21 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.  
22 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;  
23 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.  
24 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;  
25 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.  
26 1-1-24; 103-593, Article 5, Section 5-5, eff. 6-7-24; 103-593,

1 Article 90, Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24;  
2 103-909, eff. 8-9-24; 103-1040, eff. 8-9-24; revised  
3 10-10-24.)

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

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

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

1 term "any other type of remedial care" shall include nursing  
2 care and nursing home service for persons who rely on  
3 treatment by spiritual means alone through prayer for healing.

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

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

16 Notwithstanding any other provision of this Section, all  
17 tobacco cessation medications approved by the United States  
18 Food and Drug Administration and all individual and group  
19 tobacco cessation counseling services and telephone-based  
20 counseling services and tobacco cessation medications provided  
21 through the Illinois Tobacco Quitline shall be covered under  
22 the medical assistance program for persons who are otherwise  
23 eligible for assistance under this Article. The Department  
24 shall comply with all federal requirements necessary to obtain  
25 federal financial participation, as specified in 42 CFR  
26 433.15(b) (7), for telephone-based counseling services provided

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

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

20 Upon receipt of federal approval of an amendment to the  
21 Illinois Title XIX State Plan for this purpose, the Department  
22 shall authorize the Chicago Public Schools (CPS) to procure a  
23 vendor or vendors to manufacture eyeglasses for individuals  
24 enrolled in a school within the CPS system. CPS shall ensure  
25 that its vendor or vendors are enrolled as providers in the  
26 medical assistance program and in any capitated Medicaid

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

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

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

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

23 On and after July 1, 2018, the Department of Healthcare  
24 and Family Services shall provide dental services to any adult  
25 who is otherwise eligible for assistance under the medical  
26 assistance program. As used in this paragraph, "dental

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

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

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

25 Notwithstanding any other provision of this Code and  
26 subject to federal approval, the Department may adopt rules to

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

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

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

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

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

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

23 The Illinois Department shall authorize the provision of,  
24 and shall authorize payment for, screening by low-dose  
25 mammography for the presence of occult breast cancer for  
26 individuals 35 years of age or older who are eligible for

1 medical assistance under this Article, as follows:

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

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

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

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

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

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

24 (G) Molecular breast imaging (MBI) and MRI of an  
25 entire breast or breasts if a mammogram demonstrates  
26 heterogeneous or dense breast tissue or when medically

1 necessary as determined by a physician licensed to  
2 practice medicine in all of its branches, advanced  
3 practice registered nurse, or physician assistant.

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

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

16 For purposes of this Section:

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

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

24 "Low-dose mammography" means the x-ray examination of the  
25 breast using equipment dedicated specifically for mammography,  
26 including the x-ray tube, filter, compression device, and

1 image receptor, with an average radiation exposure delivery of  
2 less than one rad per breast for 2 views of an average size  
3 breast. The term also includes digital mammography and  
4 includes breast tomosynthesis.

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

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

25 On and after January 1, 2016, the Department shall ensure  
26 that all networks of care for adult clients of the Department

1 include access to at least one breast imaging Center of  
2 Imaging Excellence as certified by the American College of  
3 Radiology.

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

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

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

21 The Department shall convene an expert panel, including  
22 representatives of hospitals, free-standing breast cancer  
23 treatment centers, breast cancer quality organizations, and  
24 doctors, including radiologists that are trained in all forms  
25 of FDA-approved ~~FDA-approved~~ breast imaging technologies,  
26 breast surgeons, reconstructive breast surgeons, oncologists,

1 and primary care providers to establish quality standards for  
2 breast cancer treatment.

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

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

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

25 The Department shall devise a means of case-managing or  
26 patient navigation for beneficiaries diagnosed with breast

1 cancer. This program shall initially operate as a pilot  
2 program in areas of the State with the highest incidence of  
3 mortality related to breast cancer. At least one pilot program  
4 site shall be in the metropolitan Chicago area and at least one  
5 site shall be outside the metropolitan Chicago area. On or  
6 after July 1, 2016, the pilot program shall be expanded to  
7 include one site in western Illinois, one site in southern  
8 Illinois, one site in central Illinois, and 4 sites within  
9 metropolitan Chicago. An evaluation of the pilot program shall  
10 be carried out measuring health outcomes and cost of care for  
11 those served by the pilot program compared to similarly  
12 situated patients who are not served by the pilot program.

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

21 The Department shall provide coverage and reimbursement  
22 for a human papillomavirus (HPV) vaccine that is approved for  
23 marketing by the federal Food and Drug Administration for all  
24 persons between the ages of 9 and 45. Subject to federal  
25 approval, the Department shall provide coverage and  
26 reimbursement for a human papillomavirus (HPV) vaccine for

1 persons of the age of 46 and above who have been diagnosed with  
2 cervical dysplasia with a high risk of recurrence or  
3 progression. The Department shall disallow any  
4 preauthorization requirements for the administration of the  
5 human papillomavirus (HPV) vaccine.

6 On or after July 1, 2022, individuals who are otherwise  
7 eligible for medical assistance under this Article shall  
8 receive coverage for perinatal depression screenings for the  
9 12-month period beginning on the last day of their pregnancy.  
10 Medical assistance coverage under this paragraph shall be  
11 conditioned on the use of a screening instrument approved by  
12 the Department.

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

25 All medical providers providing medical assistance to  
26 pregnant individuals under this Code shall receive information

1 from the Department on the availability of services under any  
2 program providing case management services for addicted  
3 individuals, including information on appropriate referrals  
4 for other social services that may be needed by addicted  
5 individuals in addition to treatment for addiction.

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

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

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

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

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

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

26           (2) The Department may elect to consider and negotiate

1 financial incentives to encourage the development of  
2 Partnerships and the efficient delivery of medical care.

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

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

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

25 The Department shall apply for a waiver from the United  
26 States Health Care Financing Administration to allow for the

1 implementation of Partnerships under this Section.

2 The Illinois Department shall require health care  
3 providers to maintain records that document the medical care  
4 and services provided to recipients of Medical Assistance  
5 under this Article. Such records must be retained for a period  
6 of not less than 6 years from the date of service or as  
7 provided by applicable State law, whichever period is longer,  
8 except that if an audit is initiated within the required  
9 retention period then the records must be retained until the  
10 audit is completed and every exception is resolved. The  
11 Illinois Department shall require health care providers to  
12 make available, when authorized by the patient, in writing,  
13 the medical records in a timely fashion to other health care  
14 providers who are treating or serving persons eligible for  
15 Medical Assistance under this Article. All dispensers of  
16 medical services shall be required to maintain and retain  
17 business and professional records sufficient to fully and  
18 accurately document the nature, scope, details and receipt of  
19 the health care provided to persons eligible for medical  
20 assistance under this Code, in accordance with regulations  
21 promulgated by the Illinois Department. The rules and  
22 regulations shall require that proof of the receipt of  
23 prescription drugs, dentures, prosthetic devices and  
24 eyeglasses by eligible persons under this Section accompany  
25 each claim for reimbursement submitted by the dispenser of  
26 such medical services. No such claims for reimbursement shall

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

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

1 acceptance and payment of nursing home claims.

2 Notwithstanding any other law to the contrary, the  
3 Illinois Department shall, within 365 days after August 15,  
4 2014 (the effective date of Public Act 98-963), establish  
5 procedures to permit ID/DD facilities licensed under the ID/DD  
6 Community Care Act and MC/DD facilities licensed under the  
7 MC/DD Act to submit monthly billing claims for reimbursement  
8 purposes. Following development of these procedures, the  
9 Department shall have an additional 365 days to test the  
10 viability of the new system and to ensure that any necessary  
11 operational or structural changes to its information  
12 technology platforms are implemented.

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

22 The Illinois Department may require that all dispensers of  
23 medical services desiring to participate in the medical  
24 assistance program established under this Article disclose,  
25 under such terms and conditions as the Illinois Department may  
26 by rule establish, all inquiries from clients and attorneys

1 regarding medical bills paid by the Illinois Department, which  
2 inquiries could indicate potential existence of claims or  
3 liens for the Illinois Department.

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

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

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

1 screening as required by federal or State law.

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

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

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

24 (2) In the case of errors attributable to the Illinois  
25 Department or any of its claims processing intermediaries  
26 which result in an inability to receive, process, or

1 adjudicate a claim, the 180-day period shall not begin  
2 until the provider has been notified of the error.

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

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

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

16 In the case of long term care facilities, within 120  
17 calendar days of receipt by the facility of required  
18 prescreening information, new admissions with associated  
19 admission documents shall be submitted through the Medical  
20 Electronic Data Interchange (MEDI) or the Recipient  
21 Eligibility Verification (REV) System or shall be submitted  
22 directly to the Department of Human Services using required  
23 admission forms. Effective September 1, 2014, admission  
24 documents, including all prescreening information, must be  
25 submitted through MEDI or REV. Confirmation numbers assigned  
26 to an accepted transaction shall be retained by a facility to

1 verify timely submittal. Once an admission transaction has  
2 been completed, all resubmitted claims following prior  
3 rejection are subject to receipt no later than 180 days after  
4 the admission transaction has been completed.

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

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

23 The Illinois Department shall enter into agreements with  
24 State agencies and departments, and is authorized to enter  
25 into agreements with federal agencies and departments, under  
26 which such agencies and departments shall share data necessary

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

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

1 take any action or acquire any products or services.

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

23 The Department shall require, by rule, all providers of  
24 durable medical equipment to be accredited by an accreditation  
25 organization approved by the federal Centers for Medicare and  
26 Medicaid Services and recognized by the Department in order to

1 bill the Department for providing durable medical equipment to  
2 recipients. No later than 15 months after the effective date  
3 of the rule adopted pursuant to this paragraph, all providers  
4 must meet the accreditation requirement.

5 In order to promote environmental responsibility, meet the  
6 needs of recipients and enrollees, and achieve significant  
7 cost savings, the Department, or a managed care organization  
8 under contract with the Department, may provide recipients or  
9 managed care enrollees who have a prescription or Certificate  
10 of Medical Necessity access to refurbished durable medical  
11 equipment under this Section (excluding prosthetic and  
12 orthotic devices as defined in the Orthotics, Prosthetics, and  
13 Pedorthics Practice Act and complex rehabilitation technology  
14 products and associated services) through the State's  
15 assistive technology program's reutilization program, using  
16 staff with the Assistive Technology Professional (ATP)  
17 Certification if the refurbished durable medical equipment:  
18 (i) is available; (ii) is less expensive, including shipping  
19 costs, than new durable medical equipment of the same type;  
20 (iii) is able to withstand at least 3 years of use; (iv) is  
21 cleaned, disinfected, sterilized, and safe in accordance with  
22 federal Food and Drug Administration regulations and guidance  
23 governing the reprocessing of medical devices in health care  
24 settings; and (v) equally meets the needs of the recipient or  
25 enrollee. The reutilization program shall confirm that the  
26 recipient or enrollee is not already in receipt of the same or

1 similar equipment from another service provider, and that the  
2 refurbished durable medical equipment equally meets the needs  
3 of the recipient or enrollee. Nothing in this paragraph shall  
4 be construed to limit recipient or enrollee choice to obtain  
5 new durable medical equipment or place any additional prior  
6 authorization conditions on enrollees of managed care  
7 organizations.

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

1 (v) no later than October 1, 2013, establish procedures to  
2 permit long term care providers access to eligibility scores  
3 for individuals with an admission date who are seeking or  
4 receiving services from the long term care provider. In order  
5 to select the minimum level of care eligibility criteria, the  
6 Governor shall establish a workgroup that includes affected  
7 agency representatives and stakeholders representing the  
8 institutional and home and community-based long term care  
9 interests. This Section shall not restrict the Department from  
10 implementing lower level of care eligibility criteria for  
11 community-based services in circumstances where federal  
12 approval has been granted.

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

20 The Illinois Department shall report annually to the  
21 General Assembly, no later than the second Friday in April of  
22 1979 and each year thereafter, in regard to:

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

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

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

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

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

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

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

26 Because kidney transplantation can be an appropriate,

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

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

1 limitations on dosage.

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

17 Upon federal approval, the Department shall provide  
18 coverage and reimbursement for all drugs that are approved for  
19 marketing by the federal Food and Drug Administration and that  
20 are recommended by the federal Public Health Service or the  
21 United States Centers for Disease Control and Prevention for  
22 pre-exposure prophylaxis and related pre-exposure prophylaxis  
23 services, including, but not limited to, HIV and sexually  
24 transmitted infection screening, treatment for sexually  
25 transmitted infections, medical monitoring, assorted labs, and  
26 counseling to reduce the likelihood of HIV infection among

1 individuals who are not infected with HIV but who are at high  
2 risk of HIV infection.

3 A federally qualified health center, as defined in Section  
4 1905(1)(2)(B) of the federal Social Security Act, shall be  
5 reimbursed by the Department in accordance with the federally  
6 qualified health center's encounter rate for services provided  
7 to medical assistance recipients that are performed by a  
8 dental hygienist, as defined under the Illinois Dental  
9 Practice Act, working under the general supervision of a  
10 dentist and employed by a federally qualified health center.

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

18 Subject to approval by the federal Centers for Medicare  
19 and Medicaid Services of a Title XIX State Plan amendment  
20 electing the Program of All-Inclusive Care for the Elderly  
21 (PACE) as a State Medicaid option, as provided for by Subtitle  
22 I (commencing with Section 4801) of Title IV of the Balanced  
23 Budget Act of 1997 (Public Law 105-33) and Part 460  
24 (commencing with Section 460.2) of Subchapter E of Title 42 of  
25 the Code of Federal Regulations, PACE program services shall  
26 become a covered benefit of the medical assistance program,

1 subject to criteria established in accordance with all  
2 applicable laws.

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

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

18 Notwithstanding any other provision of this Code, the  
19 medical assistance program shall, subject to federal approval,  
20 reimburse hospitals for costs associated with a newborn  
21 screening test for the presence of metachromatic  
22 leukodystrophy, as required under the Newborn Metabolic  
23 Screening Act, at a rate not less than the fee charged by the  
24 Department of Public Health. Notwithstanding any other  
25 provision of this Code, the medical assistance program shall,  
26 subject to appropriation and federal approval, also reimburse

1 hospitals for costs associated with all newborn screening  
2 tests added on and after August 9, 2024 (the effective date of  
3 Public Act 103-909) ~~this amendatory Act of the 103rd General~~  
4 ~~Assembly~~ to the Newborn Metabolic Screening Act and required  
5 to be performed under that Act at a rate not less than the fee  
6 charged by the Department of Public Health. The Department  
7 shall seek federal approval before the implementation of the  
8 newborn screening test fees by the Department of Public  
9 Health.

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

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

26 Subject to federal approval, for dates of services on and

1 after January 1, 2026, over-the-counter choline dietary  
2 supplements for pregnant persons shall be covered under the  
3 medical assistance program.

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

17 ARTICLE 45.

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

20 (305 ILCS 5/11-4) (from Ch. 23, par. 11-4)

21 Sec. 11-4. Applications; assistance in making  
22 applications. An initial application for public assistance  
23 shall be deemed an application for all such benefits to which

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

24 The County departments, local governmental units and the  
25 Illinois Department shall assist applicants for public  
26 assistance to properly complete their applications. Such

1 assistance shall include, but not be limited to, assistance in  
2 securing evidence in support of their eligibility.

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

4 ARTICLE 66.

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

7 (305 ILCS 5/14-12)

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

11 (a) Inpatient hospital services. Effective ~~for discharges~~  
12 on and after the effective date of this amendatory Act of the  
13 104th General Assembly July 1, 2014, reimbursement for  
14 inpatient general acute care services shall utilize the All  
15 Patient Refined Diagnosis Related Grouping (APR-DRG) software,  
16 ~~version 30,~~ distributed by Solventum<sup>TM</sup> previously known as 3M<sup>TM</sup>  
17 Health Information System. Solventum<sup>TM</sup> shall be the exclusive  
18 provider of this software unless the Department determines  
19 that Solventum<sup>TM</sup> is unable to meet the required operational or  
20 contractual terms. Only under these circumstances may an  
21 alternative authorized provider of the software be considered.

22 (1) The Department shall establish Medicaid weighting  
23 factors to be used in the reimbursement system established

1 under this subsection. Initial weighting factors shall be  
2 the weighting factors as published by the authorized  
3 provider of this software ~~3M Health Information System,~~  
4 ~~associated with Version 30.0~~ adjusted for the Illinois  
5 experience.

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

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

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

24 (5) The Department shall define those hospitals or  
25 distinct parts of hospitals that shall be exempt from the  
26 APR-DRG reimbursement system established under this

1 Section. The Department shall publish these hospitals'  
2 inpatient rates on its website no later than 10 calendar  
3 days prior to their effective date.

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

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

16 (7.5) (Blank).

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

24 (9) Beginning July 1, 2018, in addition to the  
25 statewide-standardized amount, the Department shall apply  
26 the same adjustor that is applied to trauma cases as of

1 December 31, 2017 to inpatient claims to treat patients  
2 with burns, including, but not limited to, APR-DRGs 841,  
3 842, 843, and 844.

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

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

16 (b) Outpatient hospital services. Effective on and after  
17 the effective date of this amendatory Act of the 104th General  
18 Assembly, for dates of service on and after July 1, 2014,  
19 reimbursement for outpatient services shall utilize the  
20 Enhanced Ambulatory Procedure Grouping (EAPG) software  
21 ~~version 3.7~~ distributed by Solventum<sup>TM</sup> previously known as 3M<sup>TM</sup>  
22 Health Information System. Solventum<sup>TM</sup> shall be the exclusive  
23 provider of this software unless the Agency determines that  
24 Solventum<sup>TM</sup> is unable to meet the required operational or  
25 contractual terms. Only under these circumstances may an  
26 alternative authorized provider of the software be considered.

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

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

10           (A) The initial statewide standardized amounts,  
11 with the labor portion adjusted by the Calendar Year  
12 2013 Medicare Outpatient Prospective Payment System  
13 wage index with reclassifications, shall be published  
14 by the Department on its website no later than 10  
15 calendar days prior to their effective date.

16           (B) The Department shall establish adjustments to  
17 the statewide-standardized amounts for each Critical  
18 Access Hospital, as designated by the Department of  
19 Public Health in accordance with 42 CFR 485, Subpart  
20 F. For outpatient services provided on or before June  
21 30, 2018, the EAPG standardized amounts are determined  
22 separately for each critical access hospital such that  
23 simulated EAPG payments using outpatient base period  
24 paid claim data plus payments under Section 5A-12.4 of  
25 this Code net of the associated tax costs are equal to  
26 the estimated costs of outpatient base period claims

1 data with a rate year cost inflation factor applied.

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

13 (4) Beginning July 1, 2018, in addition to the  
14 statewide standardized amounts, the Department shall make  
15 an add-on payment for outpatient expensive devices and  
16 drugs. This add-on payment shall at least apply to claim  
17 lines that: (i) are assigned with one of the following  
18 EAPGs: 490, 1001 to 1020, and coded with one of the  
19 following revenue codes: 0274 to 0276, 0278; or (ii) are  
20 assigned with one of the following EAPGs: 430 to 441, 443,  
21 444, 460 to 465, 495, 496, 1090. The add-on payment shall  
22 be calculated as follows: the claim line's covered charges  
23 multiplied by the hospital's total acute cost to charge  
24 ratio, less the claim line's EAPG payment plus \$1,000,  
25 multiplied by 0.8.

26 (5) Beginning July 1, 2018, the statewide-standardized

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

8 (6) Effective for dates of service on or after July 1,  
9 2018, the Department shall establish adjustments to the  
10 statewide-standardized amounts for each Critical Access  
11 Hospital, as designated by the Department of Public Health  
12 in accordance with 42 CFR 485, Subpart F, such that each  
13 Critical Access Hospital's standardized amount for  
14 outpatient services shall be increased by the applicable  
15 uniform percentage determined pursuant to paragraph (5) of  
16 this subsection. It is the intent of the General Assembly  
17 that the adjustments required under this paragraph (6) by  
18 Public Act 100-1181 shall be applied retroactively to  
19 claims for dates of service provided on or after July 1,  
20 2018.

21 (7) Effective for dates of service on or after March  
22 8, 2019 (the effective date of Public Act 100-1181), the  
23 Department shall recalculate and implement an updated  
24 statewide-standardized amount for outpatient services  
25 provided by hospitals that are not Critical Access  
26 Hospitals to reflect the applicable uniform percentage

1           determined pursuant to paragraph (5).

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

16                   (2) It is the intent of the General Assembly that  
17          the recalculations required under this paragraph (7)  
18          by Public Act 100-1181 shall be applied prospectively  
19          to claims for dates of service provided on or after  
20          March 8, 2019 (the effective date of Public Act  
21          100-1181) and that no recoupment or repayment by the  
22          Department or an MCO of payments attributable to  
23          recalculation under this paragraph (7), issued to the  
24          hospital for dates of service on or after July 1, 2018  
25          and before March 8, 2019 (the effective date of Public  
26          Act 100-1181), shall be permitted.

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

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

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

20          (c) In consultation with the hospital community, the  
21          Department is authorized to replace 89 Ill. Adm. Code 152.150  
22          as published in 38 Ill. Reg. 4980 through 4986 within 12 months  
23          of June 16, 2014 (the effective date of Public Act 98-651). If  
24          the Department does not replace these rules within 12 months  
25          of June 16, 2014 (the effective date of Public Act 98-651), the  
26          rules in effect for 152.150 as published in 38 Ill. Reg. 4980

1 through 4986 shall remain in effect until modified by rule by  
2 the Department. Nothing in this subsection shall be construed  
3 to mandate that the Department file a replacement rule.

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

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

19 (2) After the transition period, if the Department  
20 reduces payments from the transitional hospital access  
21 pool, it shall increase base rates, develop new adjustors,  
22 adjust current adjustors, develop new hospital access  
23 payments based on updated information, or any combination  
24 thereof by an amount equal to the decreases proposed in  
25 the transitional hospital access pool payments, ensuring  
26 that the entire transitional hospital access pool amount

1 shall continue to be used for hospital payments.

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

9 (1) Phase 1. In State fiscal years 2019 through 2020,  
10 the Department shall allocate funds from the transitional  
11 access hospital pool to create a hospital transformation  
12 pool of at least \$262,906,870 annually and make hospital  
13 transformation payments to hospitals. Subject to Section  
14 5A-16, in State fiscal years 2019 and 2020, an Illinois  
15 hospital that received either a transitional hospital  
16 access payment under subsection (d) or a supplemental  
17 payment under subsection (f) of this Section in State  
18 fiscal year 2018, shall receive a hospital transformation  
19 payment as follows:

20 (A) If the hospital's Rate Year 2017 Medicaid  
21 inpatient utilization rate is equal to or greater than  
22 45%, the hospital transformation payment shall be  
23 equal to 100% of the sum of its transitional hospital  
24 access payment authorized under subsection (d) and any  
25 supplemental payment authorized under subsection (f).

26 (B) If the hospital's Rate Year 2017 Medicaid

1 inpatient utilization rate is equal to or greater than  
2 25% but less than 45%, the hospital transformation  
3 payment shall be equal to 75% of the sum of its  
4 transitional hospital access payment authorized under  
5 subsection (d) and any supplemental payment authorized  
6 under subsection (f).

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

13 (2) Phase 2.

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

17 (B) Because there are communities in Illinois that  
18 experience significant health care disparities due to  
19 systemic racism, as recently emphasized by the  
20 COVID-19 pandemic, aggravated by social determinants  
21 of health and a lack of sufficiently allocated health  
22 care ~~healthcare~~ resources, particularly  
23 community-based services, preventive care, obstetric  
24 care, chronic disease management, and specialty care,  
25 the Department shall establish a health care  
26 transformation program that shall be supported by the

1 transformation funding pool. It is the intention of  
2 the General Assembly that innovative partnerships  
3 funded by the pool must be designed to establish or  
4 improve integrated health care delivery systems that  
5 will provide significant access to the Medicaid and  
6 uninsured populations in their communities, as well as  
7 improve health care equity. It is also the intention  
8 of the General Assembly that partnerships recognize  
9 and address the disparities revealed by the COVID-19  
10 pandemic, as well as the need for post-COVID care.  
11 During State fiscal years 2021 through 2027, the  
12 hospital and health care transformation program shall  
13 be supported by an annual transformation funding pool  
14 of up to \$150,000,000, pending federal matching funds,  
15 to be allocated during the specified fiscal years for  
16 the purpose of facilitating hospital and health care  
17 transformation. No disbursement of moneys for  
18 transformation projects from the transformation  
19 funding pool described under this Section shall be  
20 considered an award, a grant, or an expenditure of  
21 grant funds. Funding agreements made in accordance  
22 with the transformation program shall be considered  
23 purchases of care under the Illinois Procurement Code,  
24 and funds shall be expended by the Department in a  
25 manner that maximizes federal funding to expend the  
26 entire allocated amount.

1           The Department shall convene, within 30 days after  
2           March 12, 2021 (the effective date of Public Act  
3           101-655), a workgroup that includes subject matter  
4           experts on health care ~~healthcare~~ disparities and  
5           stakeholders from distressed communities, which could  
6           be a subcommittee of the Medicaid Advisory Committee,  
7           to review and provide recommendations on how  
8           Department policy, including health care  
9           transformation, can improve health disparities and the  
10          impact on communities disproportionately affected by  
11          COVID-19. The workgroup shall consider and make  
12          recommendations on the following issues: a community  
13          safety-net designation of certain hospitals, racial  
14          equity, and a regional partnership to bring additional  
15          specialty services to communities.

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

26           (D) As provided in subsection (a-20) of Section

1           32.5 of the Emergency Medical Services (EMS) Systems  
2           Act, a hospital that received hospital transformation  
3           payments under this Section may convert to a  
4           freestanding emergency center. To be eligible for such  
5           a conversion, the hospital must submit to the  
6           Department of Public Health approval from the  
7           Department that the project is a part of the  
8           hospital's transformation.

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

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

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

23                 (iii) the proposal shall be specifically  
24                 designed to improve health care ~~healthcare~~  
25                 outcomes and reduce health care ~~healthcare~~  
26                 disparities, and improve the coordination,

1 effectiveness, and efficiency of care delivery;

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

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

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

12 (F) Entities eligible to be funded.

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

20 (ii) The Department shall prioritize  
21 partnerships from distressed communities, which  
22 include Business Enterprise Program certified  
23 vendors or other entities controlled and managed  
24 by minorities or women and also include one or  
25 more of the following: safety-net hospitals,  
26 critical access hospitals, the campuses of

1 hospitals that have closed since January 1, 2018,  
2 or other health care ~~healthcare~~ providers designed  
3 to address specific health care ~~healthcare~~  
4 disparities, including the impact of COVID-19 on  
5 individuals and the community and the need for  
6 post-COVID care. All funded proposals must include  
7 specific measurable goals and metrics related to  
8 improved outcomes and reduced disparities which  
9 shall be tracked by the Department.

10 (iii) The Department should target the funding  
11 in the following ways: \$30,000,000 of  
12 transformation funds to projects that are a  
13 collaboration between a safety-net hospital,  
14 particularly community safety-net hospitals, and  
15 other providers and designed to address specific  
16 health care ~~healthcare~~ disparities, \$20,000,000 of  
17 transformation funds to collaborations between  
18 safety-net hospitals and a larger hospital partner  
19 that increases specialty care in distressed  
20 communities, \$30,000,000 of transformation funds  
21 to projects that are a collaboration between  
22 hospitals and other providers in distressed areas  
23 of the State designed to address specific health  
24 care ~~healthcare~~ disparities, \$15,000,000 to  
25 collaborations between critical access hospitals  
26 and other providers designed to address specific

1           health care ~~healthcare~~ disparities, and  
2           \$15,000,000 to cross-provider collaborations  
3           designed to address specific health care  
4           ~~healthcare~~ disparities, and \$5,000,000 to  
5           collaborations that focus on workforce  
6           development.

7           (iv) The Department may allocate up to  
8           \$5,000,000 for planning, racial equity analysis,  
9           or consulting resources for the Department or  
10          entities without the resources to develop a plan  
11          to meet the criteria of this Section. Any contract  
12          for consulting services issued by the Department  
13          under this subparagraph shall comply with the  
14          provisions of Section 5-45 of the State Officials  
15          and Employees Ethics Act. Based on availability of  
16          federal funding, the Department may directly  
17          procure consulting services or provide funding to  
18          the collaboration. The provision of resources  
19          under this subparagraph is not a guarantee that a  
20          project will be approved.

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

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

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

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

24 (iii) A complete budget, including an overall  
25 timeline and a detailed pathway to sustainability  
26 within a 5-year period, specifying other sources

1 of funding, such as in-kind, cost-sharing, or  
2 private donations, particularly for capital needs.  
3 There is an expectation that parties to the  
4 transformation project dedicate resources to the  
5 extent they are able and that these expectations  
6 are delineated separately for each entity in the  
7 proposal.

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

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

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

24 (vii) A clear statement of the level of  
25 commitment the project will include for minorities  
26 and women in contracting opportunities, including

1 as equity partners where applicable, or as  
2 subcontractors and suppliers in all phases of the  
3 project.

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

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

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

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

23 (xii) Data on the number of existing employees  
24 by various job categories and wage levels by the  
25 zip code of the employees' residence and  
26 benchmarks for the continued maintenance and

1 improvement of these levels. The proposal must  
2 also describe any retraining or other workforce  
3 development planned for the new project.

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

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

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

15 (H) The Department shall evaluate proposals for  
16 compliance with the criteria listed under subparagraph  
17 (G). Proposals meeting all of the criteria may be  
18 eligible for funding with the areas of focus  
19 prioritized as described in item (ii) of subparagraph  
20 (F). Based on the funds available, the Department may  
21 negotiate funding agreements with approved applicants  
22 to maximize federal funding. Nothing in this  
23 subsection requires that an approved project be funded  
24 to the level requested. Agreements shall specify the  
25 amount of funding anticipated annually, the  
26 methodology of payments, the limit on the number of

1 years such funding may be provided, and the milestones  
2 and quality metrics that must be met by the projects in  
3 order to continue to receive funding during each year  
4 of the program. Agreements shall specify the terms and  
5 conditions under which a health care facility that  
6 receives funds under a purchase of care agreement and  
7 closes in violation of the terms of the agreement must  
8 pay an early closure fee no greater than 50% of the  
9 funds it received under the agreement, prior to the  
10 Health Facilities and Services Review Board  
11 considering an application for closure of the  
12 facility. Any project that is funded shall be required  
13 to provide quarterly written progress reports, in a  
14 form prescribed by the Department, and at a minimum  
15 shall include the progress made in achieving any  
16 milestones or metrics or Business Enterprise Program  
17 commitments in its plan. The Department may reduce or  
18 end payments, as set forth in transformation plans, if  
19 milestones or metrics or Business Enterprise Program  
20 commitments are not achieved. The Department shall  
21 seek to make payments from the transformation fund in  
22 a manner that is eligible for federal matching funds.

23 In reviewing the proposals, the Department shall  
24 take into account the needs of the community, data  
25 from the study commissioned by the Department from the  
26 University of Illinois-Chicago if applicable, feedback

1 from public comment on the Department's website, as  
2 well as how the proposal meets the criteria listed  
3 under subparagraph (G). Alignment with the  
4 Department's overall strategic initiatives shall be an  
5 important factor. To the extent that fiscal year  
6 funding is not adequate to fund all eligible projects  
7 that apply, the Department shall prioritize  
8 applications that most comprehensively and effectively  
9 address the criteria listed under subparagraph (G).

10 (3) (Blank).

11 (4) Hospital Transformation Review Committee. There is  
12 created the Hospital Transformation Review Committee. The  
13 Committee shall consist of 14 members. No later than 30  
14 days after March 12, 2018 (the effective date of Public  
15 Act 100-581), the 4 legislative leaders shall each appoint  
16 3 members; the Governor shall appoint the Director of  
17 Healthcare and Family Services, or his or her designee, as  
18 a member; and the Director of Healthcare and Family  
19 Services shall appoint one member. Any vacancy shall be  
20 filled by the applicable appointing authority within 15  
21 calendar days. The members of the Committee shall select a  
22 Chair and a Vice-Chair from among its members, provided  
23 that the Chair and Vice-Chair cannot be appointed by the  
24 same appointing authority and must be from different  
25 political parties. The Chair shall have the authority to  
26 establish a meeting schedule and convene meetings of the

1 Committee, and the Vice-Chair shall have the authority to  
2 convene meetings in the absence of the Chair. The  
3 Committee may establish its own rules with respect to  
4 meeting schedule, notice of meetings, and the disclosure  
5 of documents; however, the Committee shall not have the  
6 power to subpoena individuals or documents and any rules  
7 must be approved by 9 of the 14 members. The Committee  
8 shall perform the functions described in this Section and  
9 advise and consult with the Director in the administration  
10 of this Section. In addition to reviewing and approving  
11 the policies, procedures, and rules for the hospital and  
12 health care transformation program, the Committee shall  
13 consider and make recommendations related to qualifying  
14 criteria and payment methodologies related to safety-net  
15 hospitals and children's hospitals. Members of the  
16 Committee appointed by the legislative leaders shall be  
17 subject to the jurisdiction of the Legislative Ethics  
18 Commission, not the Executive Ethics Commission, and all  
19 requests under the Freedom of Information Act shall be  
20 directed to the applicable Freedom of Information officer  
21 for the General Assembly. The Department shall provide  
22 operational support to the Committee as necessary. The  
23 Committee is dissolved on April 1, 2019.

24 (e) Beginning 36 months after initial implementation, the  
25 Department shall update the reimbursement components in  
26 subsections (a) and (b), including standardized amounts and

1 weighting factors, and at least once every 4 years and no more  
2 frequently than annually thereafter. The Department shall  
3 publish these updates on its website no later than 30 calendar  
4 days prior to their effective date.

5 (f) Continuation of supplemental payments. Any  
6 supplemental payments authorized under 89 Illinois  
7 Administrative Code 148 effective January 1, 2014 and that  
8 continue during the period of July 1, 2014 through December  
9 31, 2014 shall remain in effect as long as the assessment  
10 imposed by Section 5A-2 that is in effect on December 31, 2017  
11 remains in effect.

12 (g) Notwithstanding subsections (a) through (f) of this  
13 Section and notwithstanding the changes authorized under  
14 Section 5-5b.1, any updates to the system shall not result in  
15 any diminishment of the overall effective rates of  
16 reimbursement as of the implementation date of the new system  
17 (July 1, 2014). These updates shall not preclude variations in  
18 any individual component of the system or hospital rate  
19 variations. Nothing in this Section shall prohibit the  
20 Department from increasing the rates of reimbursement or  
21 developing payments to ensure access to hospital services.  
22 Nothing in this Section shall be construed to guarantee a  
23 minimum amount of spending in the aggregate or per hospital as  
24 spending may be impacted by factors, including, but not  
25 limited to, the number of individuals in the medical  
26 assistance program and the severity of illness of the

1 individuals.

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

7 (i) Except for subsections (g) and (h) of this Section,  
8 the Department shall, pursuant to subsection (c) of Section  
9 5-40 of the Illinois Administrative Procedure Act, provide for  
10 presentation at the June 2014 hearing of the Joint Committee  
11 on Administrative Rules (JCAR) additional written notice to  
12 JCAR of the following rules in order to commence the second  
13 notice period for the following rules: rules published in the  
14 Illinois Register, rule dated February 21, 2014 at 38 Ill.  
15 Reg. 4559 (Medical Payment), 4628 (Specialized Health Care  
16 Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic  
17 Related Grouping (DRG) Prospective Payment System (PPS)), and  
18 4977 (Hospital Reimbursement Changes), and published in the  
19 Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499  
20 (Specialized Health Care Delivery Systems) and 6505 (Hospital  
21 Services).

22 (j) Out-of-state hospitals. Beginning July 1, 2018, for  
23 purposes of determining for State fiscal years 2019 and 2020  
24 and subsequent fiscal years the hospitals eligible for the  
25 payments authorized under subsections (a) and (b) of this  
26 Section, the Department shall include out-of-state hospitals

1 that are designated a Level I pediatric trauma center or a  
2 Level I trauma center by the Department of Public Health as of  
3 December 1, 2017.

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

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

9 (Source: P.A. 102-682, eff. 12-10-21; 102-1037, eff. 6-2-22;  
10 103-102, eff. 6-16-23; 103-154, eff. 6-30-23; revised  
11 10-16-24.)

12 ARTICLE 67.

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

15 (305 ILCS 5/10-3.5 new)

16 Sec. 10-3.5. Connecting parents to available resources.  
17 Beginning July 1, 2025, subject to appropriation and the  
18 availability of federal matching funds for the costs to the  
19 Department of Healthcare and Family Services for the  
20 implementation of this Section, the Illinois Department shall  
21 enter into agreements with other State agencies, including,  
22 but not limited to, the Department of Employment Security and  
23 the Department of Central Management Services, to implement a

1 program designed to connect available resources to  
2 noncustodial parents whose families are receiving child  
3 support enforcement services; who have a child support order  
4 or are cooperating to establish a child support order; and who  
5 are unemployed or underemployed or at risk of not being able to  
6 comply with their support order. The program shall seek to  
7 connect parents with resources providing: job search  
8 assistance; job readiness training; job development and job  
9 placement services; skills assessments to facilitate job  
10 placement; job retention services; work supports; and  
11 occupational training and other skills training related to  
12 employment. The opportunities provided to program participants  
13 shall include opportunities offered by employers located in  
14 the State, including, but not limited to, State employment.

15 ARTICLE 68.

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

18 (5 ILCS 100/5-45.65 new)

19 Sec. 5-45.65. Emergency rulemaking; Medicaid managed care  
20 organization practices. To provide for the expeditious and  
21 timely implementation of changes made by this amendatory Act  
22 of the 104th General Assembly to subsection (g-13) of Section  
23 5-30.1 of the Illinois Public Aid Code, emergency rules

1 implementing the changes made by this amendatory Act of the  
2 104th General Assembly to subsection (g-13) of Section 5-30.1  
3 of the Illinois Public Aid Code may be adopted in accordance  
4 with Section 5-45 by the Department of Healthcare and Family  
5 Services. The adoption of emergency rules authorized by  
6 Section 5-45 and this Section is deemed to be necessary for the  
7 public interest, safety, and welfare.

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

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

12 (305 ILCS 5/5-30.1)

13 Sec. 5-30.1. Managed care protections.

14 (a) As used in this Section:

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

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

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

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

10 (2) serious impairment to bodily functions;

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

12 (4) inadequately controlled pain; or

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

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

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

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

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

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

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

16 "Post-stabilization medical services" means health care  
17 services provided to an enrollee that are furnished in a  
18 hospital by a provider that is qualified to furnish such  
19 services and determined to be medically necessary by the  
20 provider and directly related to the emergency medical  
21 condition following stabilization.

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

26 "Service authorization determination" means a decision

1 made by a service authorization program in advance of,  
2 concurrent to, or after the provision of a health care service  
3 to approve, change the level of care, partially deny, deny, or  
4 otherwise limit coverage and reimbursement for a health care  
5 service upon review of a service authorization request.

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

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

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

25 (b) As provided by Section 5-16.12, managed care  
26 organizations are subject to the provisions of the Managed

1 Care Reform and Patient Rights Act.

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

14 (d) (Blank).

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

19 (1) The MCO shall not impose any service authorization  
20 program requirements for emergency services, including,  
21 but not limited to, prior authorization, prior approval,  
22 pre-certification, certification of admission, concurrent  
23 review, or retrospective review.

24 (A) Notification period: Hospitals shall notify  
25 the enrollee's Medicaid MCO within 48 hours of the  
26 date and time the order for inpatient admission is

1           written. Notification shall be limited to advising the  
2           MCO that the patient has been admitted to a hospital  
3           inpatient level of care.

4           (B) If the admitting hospital complies with the  
5           notification provisions of subparagraph (A), the  
6           Medicaid MCO may not initiate concurrent review before  
7           the end of the inpatient stabilization period. If the  
8           admitting hospital does not comply with the  
9           notification requirements in subparagraph (A), the  
10          Medicaid MCO may initiate concurrent review for the  
11          continuation of the stay beginning at the end of the  
12          48-hour notification period.

13          (C) Coverage for services provided during the  
14          48-hour notification period may not be retrospectively  
15          denied.

16          (2) The MCO shall cover emergency services provided to  
17          enrollees who are temporarily away from their residence  
18          and outside the contracting area to the extent that the  
19          enrollees would be entitled to the emergency services if  
20          they still were within the contracting area.

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

25          (4) The MCO shall not condition coverage for emergency  
26          services on the treating provider notifying the MCO of the

1           enrollee's emergency medical screening examination and  
2           treatment within 10 days after presentation for emergency  
3           services.

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

19          (6) The MCO's financial responsibility for  
20          post-stabilization medical services it has not  
21          pre-approved ends when:

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

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

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

4 (D) the enrollee is discharged.

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

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

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

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

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

16 (5) the MCO or its URO and the treating provider, if  
17 the treating provider is a non-affiliated provider, could  
18 not reach an agreement concerning the enrollee's care and  
19 an affiliated provider was unavailable for a consultation,  
20 in which case the MCO must pay for such services rendered  
21 by the treating non-affiliated provider until an  
22 affiliated provider was reached and either concurred with  
23 the treating non-affiliated provider's plan of care or  
24 assumed responsibility for the enrollee's care. Such  
25 payment shall be made at the default rate of reimbursement  
26 paid under the State's Medicaid fee-for-service program

1 methodology, including all policy adjusters, including,  
2 but not limited to, Medicaid High Volume Adjustments,  
3 Medicaid Percentage Adjustments, Outpatient High Volume  
4 Adjustments, and all outlier add-on adjustments to the  
5 extent that such adjustments are incorporated in the  
6 development of the applicable MCO capitated rates.

7 (f) Network adequacy and transparency.

8 (1) The Department shall:

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

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

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

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

19 (E) require MCOs to ensure that any  
20 Medicaid-certified provider under contract with an MCO  
21 and previously submitted on a roster on the date of  
22 service is paid for any medically necessary,  
23 Medicaid-covered, and authorized service rendered to  
24 any of the MCO's enrollees, regardless of inclusion on  
25 the MCO's published and publicly available directory  
26 of available providers; and

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

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

21 (g) Timely payment of claims.

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

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

1 receiving that claim.

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

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

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

17 (4) (A) The Department shall require MCOs to expedite  
18 payments to providers identified on the Department's  
19 expedited provider list, determined in accordance with 89  
20 Ill. Adm. Code 140.71(b), on a schedule at least as  
21 frequently as the providers are paid under the  
22 Department's fee-for-service expedited provider schedule.

23 (B) Compliance with the expedited provider requirement  
24 may be satisfied by an MCO through the use of a Periodic  
25 Interim Payment (PIP) program that has been mutually  
26 agreed to and documented between the MCO and the provider,

1 if the PIP program ensures that any expedited provider  
2 receives regular and periodic payments based on prior  
3 period payment experience from that MCO. Total payments  
4 under the PIP program may be reconciled against future PIP  
5 payments on a schedule mutually agreed to between the MCO  
6 and the provider.

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

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

13 (1) in no instance shall a medically necessary covered  
14 service rendered in good faith, based upon eligibility  
15 information documented by the provider, be denied coverage  
16 or diminished in payment amount if the eligibility or  
17 coverage information available at the time the service was  
18 rendered is later found to be inaccurate in the assignment  
19 of coverage responsibility between MCOs or the  
20 fee-for-service system, except for instances when an  
21 individual is deemed to have not been eligible for  
22 coverage under the Illinois Medicaid program; and

23 (2) the Department shall, by December 31, 2016, adopt  
24 rules establishing policies that shall be included in the  
25 Medicaid managed care policy and procedures manual  
26 addressing payment resolutions in situations in which a

1 provider renders services based upon information obtained  
2 after verifying a patient's eligibility and coverage plan  
3 through either the Department's current enrollment system  
4 or a system operated by the coverage plan identified by  
5 the patient presenting for services:

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

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

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

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

20 (A) the extension of the timely filing period;

21 (B) retroactive prior authorizations; and

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

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

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

7           (g-6) MCO Performance Metrics Report.

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

12                   (A) claims payment, including timeliness and  
13                   accuracy;

14                   (B) prior authorizations;

15                   (C) grievance and appeals;

16                   (D) utilization statistics;

17                   (E) provider disputes;

18                   (F) provider credentialing; and

19                   (G) member and provider customer service.

20          (2) The Department shall ensure that the metrics  
21          report is accessible to providers online by January 1,  
22          2017.

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

1 identified industry.

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

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

16 (g-8) Dispute resolution process. The Department shall  
17 maintain a provider complaint portal through which a provider  
18 can submit to the Department unresolved disputes with an MCO.  
19 An unresolved dispute means an MCO's decision that denies in  
20 whole or in part a claim for reimbursement to a provider for  
21 health care services rendered by the provider to an enrollee  
22 of the MCO with which the provider disagrees. Disputes shall  
23 not be submitted to the portal until the provider has availed  
24 itself of the MCO's internal dispute resolution process.  
25 Disputes that are submitted to the MCO internal dispute  
26 resolution process may be submitted to the Department of

1 Healthcare and Family Services' complaint portal no sooner  
2 than 30 days after submitting to the MCO's internal process  
3 and not later than 30 days after the unsatisfactory resolution  
4 of the internal MCO process or 60 days after submitting the  
5 dispute to the MCO internal process. Multiple claim disputes  
6 involving the same MCO may be submitted in one complaint,  
7 regardless of whether the claims are for different enrollees,  
8 when the specific reason for non-payment of the claims  
9 involves a common question of fact or policy. Within 10  
10 business days of receipt of a complaint, the Department shall  
11 present such disputes to the appropriate MCO, which shall then  
12 have 30 days to issue its written proposal to resolve the  
13 dispute. The Department may grant one 30-day extension of this  
14 time frame to one of the parties to resolve the dispute. If the  
15 dispute remains unresolved at the end of this time frame or the  
16 provider is not satisfied with the MCO's written proposal to  
17 resolve the dispute, the provider may, within 30 days, request  
18 the Department to review the dispute and make a final  
19 determination. Within 30 days of the request for Department  
20 review of the dispute, both the provider and the MCO shall  
21 present all relevant information to the Department for  
22 resolution and make individuals with knowledge of the issues  
23 available to the Department for further inquiry if needed.  
24 Within 30 days of receiving the relevant information on the  
25 dispute, or the lapse of the period for submitting such  
26 information, the Department shall issue a written decision on

1 the dispute based on contractual terms between the provider  
2 and the MCO, contractual terms between the MCO and the  
3 Department of Healthcare and Family Services and applicable  
4 Medicaid policy. The decision of the Department shall be  
5 final. By January 1, 2020, the Department shall establish by  
6 rule further details of this dispute resolution process.  
7 Disputes between MCOs and providers presented to the  
8 Department for resolution are not contested cases, as defined  
9 in Section 1-30 of the Illinois Administrative Procedure Act,  
10 conferring any right to an administrative hearing.

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

14 (A) Premium revenue, with appropriate adjustments.

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

17 (i) Direct paid claims.

18 (ii) Subcapitation payments.

19 (iii) Other claim payments.

20 (iv) Direct reserves.

21 (v) Gross recoveries.

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

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

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

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

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

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

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

20           (3) By October 1, 2019, the Department shall require all  
21           MCOs to update their provider directory with information for  
22           new practitioners of existing contracted providers within 30  
23           days of receipt of a complete and accurate standardized roster  
24           template in the format approved by the Department provided  
25           that the provider is effective in the Department's provider  
26           enrollment subsystem within the IMPACT system. Such provider

1 directory shall be readily accessible for purposes of  
2 selecting an approved health care provider and comply with all  
3 other federal and State requirements.

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

16 (g-12) Notwithstanding any other provision of law, if the  
17 Department or an MCO requires submission of a claim for  
18 payment in a non-electronic format, a provider shall always be  
19 afforded a period of no less than 90 business days, as a  
20 correction period, following any notification of rejection by  
21 either the Department or the MCO to correct errors or  
22 omissions in the original submission.

23 Under no circumstances, either by an MCO or under the  
24 State's fee-for-service system, shall a provider be denied  
25 payment for failure to comply with any timely submission  
26 requirements under this Code or under any existing contract,

1 unless the non-electronic format claim submission occurs after  
2 the initial 180 days following the latest date of service on  
3 the claim, or after the 90 business days correction period  
4 following notification to the provider of rejection or denial  
5 of payment.

6 (g-13) Utilization Review Standardization and  
7 Transparency.

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

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

26 (A) guidelines related to the publication of MCO

1 authorization policies;

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

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

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

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

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

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

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

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

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

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

19 (D) provide a written report to the General  
20 Assembly, detailing the items listed in this  
21 subsection and any other metrics deemed necessary by  
22 the Department, by the second April, following June 7,  
23 2024 (the effective date of Public Act 103-593) ~~this~~  
24 ~~amendatory Act of the 103rd General Assembly~~, and each  
25 April thereafter. The Department shall make this  
26 report available within 30 days of delivery to the

1           General Assembly, on its public facing website.

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

10          (h-5) Leading indicator data sharing. By January 1, 2024,  
11 the Department shall obtain input from the Department of Human  
12 Services, the Department of Juvenile Justice, the Department  
13 of Children and Family Services, the State Board of Education,  
14 managed care organizations, providers, and clinical experts to  
15 identify and analyze key indicators and data elements that can  
16 be used in an analysis of lead indicators from assessments and  
17 data sets available to the Department that can be shared with  
18 managed care organizations and similar care coordination  
19 entities contracted with the Department as leading indicators  
20 for elevated behavioral health crisis risk for children,  
21 including data sets such as the Illinois Medicaid  
22 Comprehensive Assessment of Needs and Strengths (IM-CANS),  
23 calls made to the State's Crisis and Referral Entry Services  
24 (CARES) hotline, health services information from Health and  
25 Human Services Innovators, or other data sets that may include  
26 key indicators. The workgroup shall complete its

1 recommendations for leading indicator data elements on or  
2 before September 1, 2024. To the extent permitted by State and  
3 federal law, the identified leading indicators shall be shared  
4 with managed care organizations and similar care coordination  
5 entities contracted with the Department on or before December  
6 1, 2024 for the purpose of improving care coordination with  
7 the early detection of elevated risk. Leading indicators shall  
8 be reassessed annually with stakeholder input. The Department  
9 shall implement guidance to managed care organizations and  
10 similar care coordination entities contracted with the  
11 Department, so that the managed care organizations and care  
12 coordination entities respond to lead indicators with services  
13 and interventions that are designed to help stabilize the  
14 child.

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

19 (j) Health care information released to managed care  
20 organizations. A health care provider shall release to a  
21 Medicaid managed care organization, upon request, and subject  
22 to the Health Insurance Portability and Accountability Act of  
23 1996 and any other law applicable to the release of health  
24 information, the health care information of the MCO's  
25 enrollee, if the enrollee has completed and signed a general  
26 release form that grants to the health care provider

1 permission to release the recipient's health care information  
2 to the recipient's insurance carrier.

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

8 (l) The requirements of this Section added by Public Act  
9 102-4 shall apply to services provided on or after the first  
10 day of the month that begins 60 days after April 27, 2021 (the  
11 effective date of Public Act 102-4).

12 (m) Except where otherwise expressly specified, the  
13 requirements of this Section added by Public Act 103-593 ~~this~~  
14 ~~amendatory Act of the 103rd General Assembly~~ shall apply to  
15 services provided on and after July 1, 2026 ~~on or after July 1,~~  
16 ~~2025~~.

17 (Source: P.A. 102-4, eff. 4-27-21; 102-43, eff. 7-6-21;  
18 102-144, eff. 1-1-22; 102-454, eff. 8-20-21; 102-813, eff.  
19 5-13-22; 103-546, eff. 8-11-23; 103-593, eff. 6-7-24; 103-885,  
20 eff. 8-9-24; revised 10-7-24.)

21 (305 ILCS 5/5-30.18)

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

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

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

25 "Gold Card provider" means a provider identified by each

1 Medicaid Managed Care Organization (MCO) as qualified under  
2 the guidelines outlined by the Department in accordance with  
3 subsection (c) and thereby granted a service authorization  
4 exemption when ordering a health care service.

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

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

16 "Service authorization exemption" means an exception  
17 granted by a Medicaid MCO to a provider under which all service  
18 authorization requests for covered health care services,  
19 excluding pharmacy services and durable medical equipment, are  
20 automatically deemed to be medically necessary, clinically  
21 appropriate, and approved for reimbursement as ordered.

22 "Service authorization program" means any utilization  
23 review, utilization management, peer review, quality review,  
24 or other medical management activity conducted in advance of,  
25 concurrent to, or after the provision of a health care service  
26 by a Medicaid MCO, either directly or through a contracted

1 utilization review organization (URO), including, but not  
2 limited to, prior authorization, pre-certification,  
3 certification of admission, concurrent review, and  
4 retrospective review of health care services.

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

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

16 (b) In consultation with the Medicaid MCOs, a statewide  
17 association representing managed care organizations, a  
18 statewide association representing the majority of Illinois  
19 hospitals, and a statewide association representing  
20 physicians, the Department shall in accordance with the  
21 Illinois Administrative Procedure Act, adopt administrative  
22 rules no later than July 1, 2026, consistent with this  
23 Section, to require each Medicaid MCO to identify Gold Card  
24 providers with such identification initially being effective  
25 for health care services provided on and after July 1, 2026  
26 ~~2025~~.

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

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

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

19           (3) The service authorization exemption shall be valid  
20 for at least one year, shall be made by each Medicaid MCO  
21 or its URO, and shall be binding on the Medicaid MCO and  
22 its URO.

23           (4) The provider shall be required to continue to  
24 document medically necessary, clinically appropriate care  
25 and submit such documentation to the Medicaid MCO for the  
26 purpose of continuous performance monitoring. If a

1 provider fails to maintain the 90% service authorization  
2 standard, as determined on no more frequent a basis than  
3 bi-annually, the provider's service authorization  
4 exemption is subject to temporary or permanent suspension.

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

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

16 (7) Require that each Medicaid MCO or its URO use the  
17 policies and guidelines published by the Department to  
18 evaluate whether a provider meets the criteria to qualify  
19 for a service authorization exemption and the conditions  
20 under which a service authorization exemption may be  
21 rescinded, including review of the provider's service  
22 authorization determinations during the preceding calendar  
23 year.

24 (8) Require each Medicaid MCO to provide the  
25 Department a list of all providers who were denied a  
26 service authorization exemption or had a previously

1 granted service authorization exemption suspended, with  
2 such denials being subject to an annual audit conducted by  
3 an independent third-party URO to ensure their  
4 appropriateness.

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

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

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

17 (e) A service authorization program shall not deny,  
18 partially deny, reduce the level of care, or otherwise limit  
19 reimbursement to the rendering or supervising provider,  
20 including the rendering facility, for health care services  
21 ordered by a provider who qualifies for a service  
22 authorization exemption, except in cases of fraud.

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

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

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

3           (210 ILCS 85/4.5)

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

6           (a) A hospital located in a county with fewer than  
7 3,000,000 inhabitants may apply to the Department for approval  
8 to conduct its operations from more than one location within  
9 the county under a single license. At the time of the  
10 application to operate under a single license, a hospital  
11 located in a county with fewer than 125,000 inhabitants may  
12 apply to the Department for approval to conduct its operations  
13 from more than one location within contiguous counties in  
14 which both facilities are located, provided that the second  
15 county has fewer than 235,000 inhabitants. A hospital located  
16 in a county with fewer than 325,000 inhabitants may apply to  
17 the Department for approval to conduct its operations from  
18 more than one location within contiguous counties provided  
19 that the facility located in the contiguous county is  
20 separately licensed under this Act and was acquired out of  
21 bankruptcy proceedings under the United States Bankruptcy Code  
22 before the effective date of this amendatory Act of the 104th  
23 General Assembly.

24           (b) The facilities or buildings at those locations must be

1 owned or operated together by a single corporation or other  
2 legal entity serving as the licensee and must share:

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

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

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

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

18 (d) The hospital shall submit to the Department a  
19 comprehensive plan in relation to the waiver or waivers  
20 requested describing the services and operations of each  
21 facility or building and how common services or operations  
22 will be coordinated between the various locations. With the  
23 exception of items required by subsection (c), the Department  
24 is authorized to waive compliance with the hospital licensing  
25 requirements for specific buildings or facilities, provided  
26 that the hospital has documented which other building or

1 facility under its single license provides that service or  
2 operation, and that doing so would not endanger the public's  
3 health, safety, or welfare. Nothing in this Section relieves a  
4 hospital from the requirements of the Health Facilities  
5 Planning Act.

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

7 ARTICLE 73.

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

10 (210 ILCS 45/3-202.05)

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

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

- 15 (1) registered nurses;
- 16 (2) licensed practical nurses;
- 17 (3) certified nurse assistants;
- 18 (4) psychiatric services rehabilitation aides;
- 19 (5) rehabilitation and therapy aides;
- 20 (6) psychiatric services rehabilitation coordinators;
- 21 (7) assistant directors of nursing;
- 22 (8) 50% of the Director of Nurses' time; and
- 23 (9) 30% of the Social Services Directors' time.

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

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

16           Within 120 days of June 14, 2012 (the effective date of  
17 Public Act 97-689), the Department shall promulgate rules  
18 specific to the staffing requirements for facilities licensed  
19 under the Specialized Mental Health Rehabilitation Act of  
20 2013. These rules shall recognize the unique nature of  
21 individuals with chronic mental health conditions, shall  
22 include minimum requirements for specialized clinical staff,  
23 including clinical social workers, psychiatrists,  
24 psychologists, and direct care staff set forth in paragraphs  
25 (4) through (6) and any other specialized staff which may be  
26 utilized and deemed necessary to count toward staffing ratios.

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

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

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

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

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

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

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

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

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

17          (9) Nurse Practitioner, job title code 13.

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

19          (11) Occupational Therapist, job title code 18.

20          (12) Occupational Therapy Assistant, job title code  
21 19.

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

23          (14) Physical Therapist, job title code 21.

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

25          (16) Physical Therapy Assistant, job title code 23.

26          (17) Respiratory Therapist, job title code 24.

1           (18) Respiratory Therapy Technician, job title code

2           25.

3           (19) Speech/Language Pathologist, job title code 26.

4           (20) Qualified Activities Professional, job title code

5           28.

6           (21) Other Activities Staff, job title code 29.

7           (22) Qualified Social Worker, job title code 30.

8           (23) Other Social Worker, job title code 31.

9           (24) Mental Health Service Worker, job title code 34.

10          For all job title codes in this subsection, 100% of the  
11          hours worked by the staff must be counted toward the  
12          staff-to-resident ratio, except job code title 5, which is  
13          limited to 50%, and job title codes 28, 30, and 31, which are  
14          limited to 30%.

15          (b) (Blank).

16          (b-5) For purposes of the minimum staffing ratios in this  
17          Section, all residents shall be classified as requiring either  
18          skilled care or intermediate care.

19          As used in this subsection:

20          "Intermediate care" means basic nursing care and other  
21          restorative services under periodic medical direction.

22          "Skilled care" means skilled nursing care, continuous  
23          skilled nursing observations, restorative nursing, and other  
24          services under professional direction with frequent medical  
25          supervision.

26          (c) Facilities shall notify the Department within 60 days

1 after July 29, 2010 (the effective date of Public Act  
2 96-1372), in a form and manner prescribed by the Department,  
3 of the staffing ratios in effect on July 29, 2010 (the  
4 effective date of Public Act 96-1372) for both intermediate  
5 and skilled care and the number of residents receiving each  
6 level of care.

7 (d) (1) (Blank).

8 (2) (Blank).

9 (3) (Blank).

10 (4) (Blank).

11 (5) Effective January 1, 2014, the minimum staffing ratios  
12 shall be increased to 3.8 hours of nursing and personal care  
13 each day for a resident needing skilled care and 2.5 hours of  
14 nursing and personal care each day for a resident needing  
15 intermediate care.

16 (e) Ninety days after June 14, 2012 (the effective date of  
17 Public Act 97-689), a minimum of 25% of nursing and personal  
18 care time shall be provided by licensed nurses, with at least  
19 10% of nursing and personal care time provided by registered  
20 nurses. These minimum requirements shall remain in effect  
21 until an acuity based registered nurse requirement is  
22 promulgated by rule concurrent with the adoption of the  
23 Resource Utilization Group classification-based payment  
24 methodology, as provided in Section 5-5.2 of the Illinois  
25 Public Aid Code. Registered nurses and licensed practical  
26 nurses employed by a facility in excess of these requirements

1 may be used to satisfy the remaining 75% of the nursing and  
2 personal care time requirements. Notwithstanding this  
3 subsection, no staffing requirement in statute in effect on  
4 June 14, 2012 (the effective date of Public Act 97-689) shall  
5 be reduced on account of this subsection.

6 (f) The Department shall submit proposed rules for  
7 adoption by January 1, 2020 establishing a system for  
8 determining compliance with minimum staffing set forth in this  
9 Section and the requirements of 77 Ill. Adm. Code 300.1230  
10 adjusted for any waivers granted under Section 3-303.1.  
11 Compliance shall be determined quarterly by comparing the  
12 number of hours provided per resident per day using the  
13 Centers for Medicare and Medicaid Services' payroll-based  
14 journal and the facility's daily census, broken down by  
15 intermediate and skilled care as self-reported by the facility  
16 to the Department on a quarterly basis. The Department shall  
17 use the quarterly payroll-based journal and the self-reported  
18 census to calculate the number of hours provided per resident  
19 per day and compare this ratio to the minimum staffing  
20 standards required under this Section, as impacted by any  
21 waivers granted under Section 3-303.1. Discrepancies between  
22 job titles contained in this Section and the payroll-based  
23 journal shall be addressed by rule. The manner in which the  
24 Department requests payroll-based journal information to be  
25 submitted shall align with the federal Centers for Medicare  
26 and Medicaid Services' requirements that allow providers to

1 submit the quarterly data in an aggregate manner.

2 (g) Monetary penalties for non-compliance. The Department  
3 shall submit proposed rules for adoption by January 1, 2020  
4 establishing monetary penalties for facilities not in  
5 compliance with minimum staffing standards under this Section.  
6 Facilities shall be required to comply with the provisions of  
7 this subsection beginning January 1, 2025. No monetary penalty  
8 may be issued for noncompliance prior to the revised  
9 implementation date, which shall be January 1, 2025. If a  
10 facility is found to be noncompliant prior to the revised  
11 implementation date, the Department shall provide a written  
12 notice identifying the staffing deficiencies and require the  
13 facility to provide a sufficiently detailed correction plan  
14 that describes proposed and completed actions the facility  
15 will take or has taken, including hiring actions, to address  
16 the facility's failure to meet the statutory minimum staffing  
17 levels. Monetary penalties shall be imposed beginning no later  
18 than July 1, 2025, based on data for the quarter beginning  
19 January 1, 2025 through March 31, 2025 and quarterly  
20 thereafter. Monetary penalties shall be established based on a  
21 formula that calculates on a daily basis the cost of wages and  
22 benefits for the missing staffing hours. All notices of  
23 noncompliance shall include the computations used to determine  
24 noncompliance and establishing the variance between minimum  
25 staffing ratios and the Department's computations. The penalty  
26 for the first offense shall be 125% of the cost of wages and

1 benefits for the missing staffing hours. The penalty shall  
2 increase to 150% of the cost of wages and benefits for the  
3 missing staffing hours for the second offense and 200% the  
4 cost of wages and benefits for the missing staffing hours for  
5 the third and all subsequent offenses. The penalty shall be  
6 imposed regardless of whether the facility has committed other  
7 violations of this Act during the same period that the  
8 staffing offense occurred. The penalty may not be waived,  
9 except ~~but the Department shall have the discretion to~~  
10 ~~determine the gravity of the violation in situations~~ where  
11 there is no more than a 10% deviation from the staffing  
12 requirements, in which case the facility shall not receive a  
13 violation or penalty and make appropriate adjustments to the  
14 ~~penalty~~. The Department is granted discretion to waive the  
15 violation and penalty when unforeseen circumstances have  
16 occurred that resulted in call-offs of scheduled staff. This  
17 provision shall be applied no more than 6 times per quarter.  
18 Nothing in this Section diminishes a facility's right to  
19 appeal the imposition of a monetary penalty. No facility may  
20 appeal a notice of noncompliance issued during the revised  
21 implementation period. The changes made to this subsection by  
22 this amendatory Act of the 104th General Assembly in regard to  
23 nursing home staffing fines shall apply to the July 1, 2025  
24 fines based on data for the quarter beginning January 1, 2025  
25 through March 31, 2025 and quarterly thereafter.

26 (Source: P.A. 101-10, eff. 6-5-19; 102-16, eff. 6-17-21;

1 102-1118, eff. 1-18-23.)

2 (210 ILCS 45/3-209) (from Ch. 111 1/2, par. 4153-209)

3 (Text of Section before amendment by P.A. 103-1069)

4 Sec. 3-209. Required posting of information.

5 (a) Every facility shall conspicuously post for display in  
6 an area of its offices accessible to residents, employees, and  
7 visitors the following:

8 (1) Its current license;

9 (2) A description, provided by the Department, of  
10 complaint procedures established under this Act and the  
11 name, address, and telephone number of a person authorized  
12 by the Department to receive complaints;

13 (3) A copy of any order pertaining to the facility  
14 issued by the Department or a court;

15 (4) A list of the material available for public  
16 inspection under Section 3-210;

17 (5) Phone numbers and websites for rights protection  
18 services must be posted in common areas and at the main  
19 entrance and provided upon entry and at the request of  
20 residents or the resident's representative in accordance  
21 with 42 CFR 483.10(j)(4); and

22 (6) The statement "The Illinois Long-Term Care  
23 Ombudsman Program is a free resident advocacy service  
24 available to the public."

25 In accordance with F574 of the State Operations Manual for

1 Long-Term Care Facilities, the administrator shall post for  
2 all residents and at the main entrance the name, address, and  
3 telephone number of the appropriate State governmental office  
4 where complaints may be lodged in language the resident can  
5 understand, which must include notice of the grievance  
6 procedure of the facility or program as well as addresses and  
7 phone numbers for the Office of Health Care Regulation and the  
8 Long-Term Care Ombudsman Program and a website showing the  
9 information of a facility's ownership. The facility shall  
10 include a link to the Long-Term Care Ombudsman Program's  
11 website on the home page of the facility's website.

12 (b) A facility that has received a notice of violation for  
13 a violation of the minimum staffing requirements under Section  
14 3-202.05 shall display, for a consecutive 60 days immediately  
15 after the facility is notified of the violation ~~during the~~  
16 ~~period of time the facility is out of compliance~~, a notice  
17 stating in Calibri (body) font and 26-point type in black  
18 letters on an 8.5 by 11 inch white paper the following:

19 "Notice Dated: .....

20 This facility did ~~does~~ not ~~currently~~ meet the minimum staffing  
21 ratios required by law for [insert applicable quarter]. Posted  
22 at the direction of the Illinois Department of Public  
23 Health."

24 The notice must be posted, at a minimum, at all publicly used

1 exterior entryways into the facility, inside the main entrance  
2 lobby, and next to any registration desk for easily accessible  
3 viewing. The notice must also be posted on the main page of the  
4 facility's website. The Department shall have the discretion  
5 to determine the gravity of any violation and, taking into  
6 account mitigating and aggravating circumstances and facts,  
7 may reduce the requirement of, and amount of time for, posting  
8 the notice. Facilities shall not be required to post for the  
9 violation if they are within the 10% deviation of staffing  
10 requirements as provided in Section 3-202.05.

11 (Source: P.A. 101-10, eff. 6-5-19; 102-1080, eff. 1-1-23.)

12 (Text of Section after amendment by P.A. 103-1069)

13 Sec. 3-209. Required posting of information.

14 (a) Every facility shall conspicuously post for display in  
15 an area of its offices accessible to residents, employees, and  
16 visitors the following:

17 (1) Its current license;

18 (2) A description, provided by the Department, of  
19 complaint procedures established under this Act and the  
20 name, address, and telephone number of a person authorized  
21 by the Department to receive complaints;

22 (3) A copy of any order pertaining to the facility  
23 issued by the Department or a court;

24 (4) A list of the material available for public  
25 inspection under Section 3-210;

1 (5) Phone numbers and websites for rights protection  
2 services must be posted in common areas and at the main  
3 entrance and provided upon entry and at the request of  
4 residents or the resident's representative in accordance  
5 with 42 CFR 483.10(j)(4);

6 (6) The statement "The Illinois Long-Term Care  
7 Ombudsman Program is a free resident advocacy service  
8 available to the public."; and

9 (7) A description of the retaliation complaint  
10 procedures and the remedies established under this Act.

11 In accordance with F574 of the State Operations Manual for  
12 Long-Term Care Facilities, the administrator shall post for  
13 all residents and at the main entrance the name, address, and  
14 telephone number of the appropriate State governmental office  
15 where complaints may be lodged in language the resident can  
16 understand, which must include notice of the grievance  
17 procedure of the facility or program as well as addresses and  
18 phone numbers for the Office of Health Care Regulation and the  
19 Long-Term Care Ombudsman Program and a website showing the  
20 information of a facility's ownership. The facility shall  
21 include a link to the Long-Term Care Ombudsman Program's  
22 website on the home page of the facility's website.

23 (b) A facility that has received a notice of violation for  
24 a violation of the minimum staffing requirements under Section  
25 3-202.05 shall display, for a consecutive 60 days immediately  
26 after the facility is notified of the violation ~~during the~~

1 ~~period of time the facility is out of compliance,~~ a notice  
2 stating in Calibri (body) font and 26-point type in black  
3 letters on an 8.5 by 11 inch white paper the following:

4 "Notice Dated: .....

5 This facility ~~did~~ ~~does~~ not ~~currently~~ meet the minimum staffing  
6 ratios required by law for [insert applicable quarter]. Posted  
7 at the direction of the Illinois Department of Public  
8 Health."

9 The notice must be posted, at a minimum, at all publicly used  
10 exterior entryways into the facility, inside the main entrance  
11 lobby, and next to any registration desk for easily accessible  
12 viewing. The notice must also be posted on the main page of the  
13 facility's website. The Department shall have the discretion  
14 to determine the gravity of any violation and, taking into  
15 account mitigating and aggravating circumstances and facts,  
16 may reduce the requirement of, and amount of time for, posting  
17 the notice. Facilities shall not be required to post for the  
18 violation if they are within the 10% deviation of staffing  
19 requirements as provided in Section 3-202.05.

20 (Source: P.A. 102-1080, eff. 1-1-23; 103-1069, eff. 1-1-26.)

21 ARTICLE 74.

22 Section 74-5. The Illinois Public Aid Code is amended by

1 changing Section 5-5.01a as follows:

2 (305 ILCS 5/5-5.01a)

3 Sec. 5-5.01a. Supportive living facilities program.

4 (a) The Department shall establish and provide oversight  
5 for a program of supportive living facilities that seek to  
6 promote resident independence, dignity, respect, and  
7 well-being in the most cost-effective manner.

8 A supportive living facility is (i) a free-standing  
9 facility or (ii) a distinct physical and operational entity  
10 within a mixed-use building that meets the criteria  
11 established in subsection (d). A supportive living facility  
12 integrates housing with health, personal care, and supportive  
13 services and is a designated setting that offers residents  
14 their own separate, private, and distinct living units.

15 Sites for the operation of the program shall be selected  
16 by the Department based upon criteria that may include the  
17 need for services in a geographic area, the availability of  
18 funding, and the site's ability to meet the standards.

19 (b) Beginning July 1, 2014, subject to federal approval,  
20 the Medicaid rates for supportive living facilities shall be  
21 equal to the supportive living facility Medicaid rate  
22 effective on June 30, 2014 increased by 8.85%. Once the  
23 assessment imposed at Article V-G of this Code is determined  
24 to be a permissible tax under Title XIX of the Social Security  
25 Act, the Department shall increase the Medicaid rates for

1 supportive living facilities effective on July 1, 2014 by  
2 9.09%. The Department shall apply this increase retroactively  
3 to coincide with the imposition of the assessment in Article  
4 V-G of this Code in accordance with the approval for federal  
5 financial participation by the Centers for Medicare and  
6 Medicaid Services.

7 The Medicaid rates for supportive living facilities  
8 effective on July 1, 2017 must be equal to the rates in effect  
9 for supportive living facilities on June 30, 2017 increased by  
10 2.8%.

11 The Medicaid rates for supportive living facilities  
12 effective on July 1, 2018 must be equal to the rates in effect  
13 for supportive living facilities on June 30, 2018.

14 Subject to federal approval, the Medicaid rates for  
15 supportive living services on and after July 1, 2019 must be at  
16 least 54.3% of the average total nursing facility services per  
17 diem for the geographic areas defined by the Department while  
18 maintaining the rate differential for dementia care and must  
19 be updated whenever the total nursing facility service per  
20 diems are updated. Beginning July 1, 2022, upon the  
21 implementation of the Patient Driven Payment Model, Medicaid  
22 rates for supportive living services must be at least 54.3% of  
23 the average total nursing services per diem rate for the  
24 geographic areas. For purposes of this provision, the average  
25 total nursing services per diem rate shall include all add-ons  
26 for nursing facilities for the geographic area provided for in

1 Section 5-5.2. The rate differential for dementia care must be  
2 maintained in these rates and the rates shall be updated  
3 whenever nursing facility per diem rates are updated.

4 Subject to federal approval, beginning January 1, 2024,  
5 the dementia care rate for supportive living services must be  
6 no less than the non-dementia care supportive living services  
7 rate multiplied by 1.5.

8 (b-5) Subject to federal approval, beginning January 1,  
9 2025, Medicaid rates for supportive living services must be at  
10 least 54.75% of the average total nursing facility ~~services~~  
11 per diem rate for the geographic areas defined by the  
12 Department and shall include all add-ons for nursing  
13 facilities for the geographic area provided for in Section  
14 5-5.2.

15 (c) The Department may adopt rules to implement this  
16 Section. Rules that establish or modify the services,  
17 standards, and conditions for participation in the program  
18 shall be adopted by the Department in consultation with the  
19 Department on Aging, the Department of Rehabilitation  
20 Services, and the Department of Mental Health and  
21 Developmental Disabilities (or their successor agencies).

22 (d) Subject to federal approval by the Centers for  
23 Medicare and Medicaid Services, the Department shall accept  
24 for consideration of certification under the program any  
25 application for a site or building where distinct parts of the  
26 site or building are designated for purposes other than the

1 provision of supportive living services, but only if:

2 (1) those distinct parts of the site or building are  
3 not designated for the purpose of providing assisted  
4 living services as required under the Assisted Living and  
5 Shared Housing Act;

6 (2) those distinct parts of the site or building are  
7 completely separate from the part of the building used for  
8 the provision of supportive living program services,  
9 including separate entrances;

10 (3) those distinct parts of the site or building do  
11 not share any common spaces with the part of the building  
12 used for the provision of supportive living program  
13 services; and

14 (4) those distinct parts of the site or building do  
15 not share staffing with the part of the building used for  
16 the provision of supportive living program services.

17 (e) Facilities or distinct parts of facilities which are  
18 selected as supportive living facilities and are in good  
19 standing with the Department's rules are exempt from the  
20 provisions of the Nursing Home Care Act and the Illinois  
21 Health Facilities Planning Act.

22 (f) Section 9817 of the American Rescue Plan Act of 2021  
23 (Public Law 117-2) authorizes a 10% enhanced federal medical  
24 assistance percentage for supportive living services for a  
25 12-month period from April 1, 2021 through March 31, 2022.  
26 Subject to federal approval, including the approval of any

1 necessary waiver amendments or other federally required  
2 documents or assurances, for a 12-month period the Department  
3 must pay a supplemental \$26 per diem rate to all supportive  
4 living facilities with the additional federal financial  
5 participation funds that result from the enhanced federal  
6 medical assistance percentage from April 1, 2021 through March  
7 31, 2022. The Department may issue parameters around how the  
8 supplemental payment should be spent, including quality  
9 improvement activities. The Department may alter the form,  
10 methods, or timeframes concerning the supplemental per diem  
11 rate to comply with any subsequent changes to federal law,  
12 changes made by guidance issued by the federal Centers for  
13 Medicare and Medicaid Services, or other changes necessary to  
14 receive the enhanced federal medical assistance percentage.

15 (g) All applications for the expansion of supportive  
16 living dementia care settings involving sites not approved by  
17 the Department by January 1, 2024 (Public Act 103-102) may  
18 allow new elderly non-dementia units in addition to new  
19 dementia care units. The Department may approve such  
20 applications only if the application has: (1) no more than one  
21 non-dementia care unit for each dementia care unit and (2) the  
22 site is not located within 4 miles of an existing supportive  
23 living program site in Cook County (including the City of  
24 Chicago), not located within 12 miles of an existing  
25 supportive living program site in Alexander, Bond, Boone,  
26 Calhoun, Champaign, Clinton, DeKalb, DuPage Fulton, Grundy,

1 Henry, Jackson, Jersey, Johnson, Kane, Kankakee, Kendall,  
2 Lake, Macon, Macoupin, Madison, Marshall, McHenry, McLean,  
3 Menard, Mercer, Monroe, Peoria, Piatt, Rock Island, Sangamon,  
4 Stark, St. Clair, Tazewell, Vermilion, Will, Williamson,  
5 Winnebago, or Woodford counties, or not located within 25  
6 miles of an existing supportive living program site in any  
7 other county.

8 (h) Beginning January 1, 2025, subject to federal  
9 approval, for a person who is a resident of a supportive living  
10 facility under this Section, the monthly personal needs  
11 allowance shall be \$120 per month.

12 (i) ~~(h)~~ As stated in the supportive living program home  
13 and community-based service waiver approved by the federal  
14 Centers for Medicare and Medicaid Services, and beginning July  
15 1, 2025, the Department must maintain the rate add-on  
16 implemented on January 1, 2023 for the provision of 2 meals per  
17 day at no less than \$6.15 per day.

18 (j) ~~(f)~~ Subject to federal approval, the Department shall  
19 allow a certified medication aide to administer medication in  
20 a supportive living facility. For purposes of this subsection,  
21 "certified medication aide" means a person who has met the  
22 qualifications for certification under Section 79 of the  
23 Assisted Living and Shared Housing Act and assists with  
24 medication administration while under the supervision of a  
25 registered professional nurse as authorized by Section 50-75  
26 of the Nurse Practice Act. The Department may adopt rules to

1 implement this subsection.

2 (Source: P.A. 102-43, eff. 7-6-21; 102-699, eff. 4-19-22;  
3 103-102, Article 20, Section 20-5, eff. 1-1-24; 103-102,  
4 Article 100, Section 100-5, eff. 1-1-24; 103-593, Article 15,  
5 Section 15-5, eff. 6-7-24; 103-593, Article 100, Section  
6 100-5, eff. 6-7-24; 103-593, Article 165, Section 165-5, eff.  
7 6-7-24; 103-605, eff. 7-1-24; 103-886, eff. 8-9-24; revised  
8 10-8-24.)

9 ARTICLE 75.

10 Section 75-5. The Illinois Public Aid Code is amended by  
11 changing Section 5A-2 as follows:

12 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

13 (Section scheduled to be repealed on December 31, 2026)

14 Sec. 5A-2. Assessment.

15 (a)(1) Subject to Sections 5A-3 and 5A-10, for State  
16 fiscal years 2009 through 2018, or as long as continued under  
17 Section 5A-16, an annual assessment on inpatient services is  
18 imposed on each hospital provider in an amount equal to  
19 \$218.38 multiplied by the difference of the hospital's  
20 occupied bed days less the hospital's Medicare bed days,  
21 provided, however, that the amount of \$218.38 shall be  
22 increased by a uniform percentage to generate an amount equal  
23 to 75% of the State share of the payments authorized under

1 Section 5A-12.5, with such increase only taking effect upon  
2 the date that a State share for such payments is required under  
3 federal law. For the period of April through June 2015, the  
4 amount of \$218.38 used to calculate the assessment under this  
5 paragraph shall, by emergency rule under subsection (s) of  
6 Section 5-45 of the Illinois Administrative Procedure Act, be  
7 increased by a uniform percentage to generate \$20,250,000 in  
8 the aggregate for that period from all hospitals subject to  
9 the annual assessment under this paragraph.

10 (2) In addition to any other assessments imposed under  
11 this Article, effective July 1, 2016 and semi-annually  
12 thereafter through June 2018, or as provided in Section 5A-16,  
13 in addition to any federally required State share as  
14 authorized under paragraph (1), the amount of \$218.38 shall be  
15 increased by a uniform percentage to generate an amount equal  
16 to 75% of the ACA Assessment Adjustment, as defined in  
17 subsection (b-6) of this Section.

18 For State fiscal years 2009 through 2018, or as provided  
19 in Section 5A-16, a hospital's occupied bed days and Medicare  
20 bed days shall be determined using the most recent data  
21 available from each hospital's 2005 Medicare cost report as  
22 contained in the Healthcare Cost Report Information System  
23 file, for the quarter ending on December 31, 2006, without  
24 regard to any subsequent adjustments or changes to such data.  
25 If a hospital's 2005 Medicare cost report is not contained in  
26 the Healthcare Cost Report Information System, then the

1 Illinois Department may obtain the hospital provider's  
2 occupied bed days and Medicare bed days from any source  
3 available, including, but not limited to, records maintained  
4 by the hospital provider, which may be inspected at all times  
5 during business hours of the day by the Illinois Department or  
6 its duly authorized agents and employees.

7 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State  
8 fiscal years 2019 and 2020, an annual assessment on inpatient  
9 services is imposed on each hospital provider in an amount  
10 equal to \$197.19 multiplied by the difference of the  
11 hospital's occupied bed days less the hospital's Medicare bed  
12 days. For State fiscal years 2019 and 2020, a hospital's  
13 occupied bed days and Medicare bed days shall be determined  
14 using the most recent data available from each hospital's 2015  
15 Medicare cost report as contained in the Healthcare Cost  
16 Report Information System file, for the quarter ending on  
17 March 31, 2017, without regard to any subsequent adjustments  
18 or changes to such data. If a hospital's 2015 Medicare cost  
19 report is not contained in the Healthcare Cost Report  
20 Information System, then the Illinois Department may obtain  
21 the hospital provider's occupied bed days and Medicare bed  
22 days from any source available, including, but not limited to,  
23 records maintained by the hospital provider, which may be  
24 inspected at all times during business hours of the day by the  
25 Illinois Department or its duly authorized agents and  
26 employees. Notwithstanding any other provision in this

1 Article, for a hospital provider that did not have a 2015  
2 Medicare cost report, but paid an assessment in State fiscal  
3 year 2018 on the basis of hypothetical data, that assessment  
4 amount shall be used for State fiscal years 2019 and 2020.

5 (4) Subject to Sections 5A-3 and 5A-10 and to subsection  
6 (b-8), for the period of July 1, 2020 through December 31, 2020  
7 and calendar years 2021 through 2026, an annual assessment on  
8 inpatient services is imposed on each hospital provider in an  
9 amount equal to \$221.50 multiplied by the difference of the  
10 hospital's occupied bed days less the hospital's Medicare bed  
11 days, provided however: for the period of July 1, 2020 through  
12 December 31, 2020, (i) the assessment shall be equal to 50% of  
13 the annual amount; and (ii) the amount of \$221.50 shall be  
14 retroactively adjusted by a uniform percentage to generate an  
15 amount equal to 50% of the Assessment Adjustment, as defined  
16 in subsection (b-7). For the period of July 1, 2020 through  
17 December 31, 2020 and calendar years 2021 through 2026, a  
18 hospital's occupied bed days and Medicare bed days shall be  
19 determined using the most recent data available from each  
20 hospital's 2015 Medicare cost report as contained in the  
21 Healthcare Cost Report Information System file, for the  
22 quarter ending on March 31, 2017, without regard to any  
23 subsequent adjustments or changes to such data. If a  
24 hospital's 2015 Medicare cost report is not contained in the  
25 Healthcare Cost Report Information System, then the Illinois  
26 Department may obtain the hospital provider's occupied bed

1 days and Medicare bed days from any source available,  
2 including, but not limited to, records maintained by the  
3 hospital provider, which may be inspected at all times during  
4 business hours of the day by the Illinois Department or its  
5 duly authorized agents and employees. Should the change in the  
6 assessment methodology for fiscal years 2021 through December  
7 31, 2022 not be approved on or before June 30, 2020, the  
8 assessment and payments under this Article in effect for  
9 fiscal year 2020 shall remain in place until the new  
10 assessment is approved. If the assessment methodology for July  
11 1, 2020 through December 31, 2022, is approved on or after July  
12 1, 2020, it shall be retroactive to July 1, 2020, subject to  
13 federal approval and provided that the payments authorized  
14 under Section 5A-12.7 have the same effective date as the new  
15 assessment methodology. In giving retroactive effect to the  
16 assessment approved after June 30, 2020, credit toward the new  
17 assessment shall be given for any payments of the previous  
18 assessment for periods after June 30, 2020. Notwithstanding  
19 any other provision of this Article, for a hospital provider  
20 that did not have a 2015 Medicare cost report, but paid an  
21 assessment in State Fiscal Year 2020 on the basis of  
22 hypothetical data, the data that was the basis for the 2020  
23 assessment shall be used to calculate the assessment under  
24 this paragraph until December 31, 2023. Beginning July 1, 2022  
25 and through December 31, 2024, a safety-net hospital that had  
26 a change of ownership in calendar year 2021, and whose

1 inpatient utilization had decreased by 90% from the prior year  
2 and prior to the change of ownership, may be eligible to pay a  
3 tax based on hypothetical data based on a determination of  
4 financial distress by the Department. Subject to federal  
5 approval, the Department may, by January 1, 2024, develop a  
6 hypothetical tax for a specialty cancer hospital which had a  
7 structural change of ownership during calendar year 2022 from  
8 a for-profit entity to a non-profit entity, and which has  
9 experienced a decline of 60% or greater in inpatient days of  
10 care as compared to the prior owners 2015 Medicare cost  
11 report. This change of ownership may make the hospital  
12 eligible for a hypothetical tax under the new hospital  
13 provision of the assessment defined in this Section. This new  
14 hypothetical tax may be applicable from January 1, 2024  
15 through December 31, 2026.

16 (6) For calendar year 2026, and for each year thereafter  
17 in which a tax is imposed under this Section, the Department  
18 may seek to obtain a waiver from the federal Centers for  
19 Medicare and Medicaid Services of the uniformity requirements  
20 in place for the tax imposed under this Section, provided that  
21 such waiver request does not risk the assessment imposed or  
22 payments authorized under this Section from continuing. Such  
23 uniformity requirements shall only be waived for  
24 not-for-profit hospitals operating as a freestanding cancer  
25 hospital that have contracted to provide services to members  
26 served by at least 50% of the managed care organizations

1 contracted with the Department. Such tax rates imposed on a  
2 hospital shall be no more than 50% and no less than 25% of the  
3 tax imposed on all other hospitals in this State unless  
4 different rates are necessary to meet federal statistical  
5 tests necessary for continued federal financial participation.  
6 Upon federal approval of such a waiver, other tax rates  
7 imposed under this Article shall be adjusted to ensure budget  
8 neutrality.

9 (b) (Blank).

10 (b-5) (1) Subject to Sections 5A-3 and 5A-10, for the  
11 portion of State fiscal year 2012, beginning June 10, 2012  
12 through June 30, 2012, and for State fiscal years 2013 through  
13 2018, or as provided in Section 5A-16, an annual assessment on  
14 outpatient services is imposed on each hospital provider in an  
15 amount equal to .008766 multiplied by the hospital's  
16 outpatient gross revenue, provided, however, that the amount  
17 of .008766 shall be increased by a uniform percentage to  
18 generate an amount equal to 25% of the State share of the  
19 payments authorized under Section 5A-12.5, with such increase  
20 only taking effect upon the date that a State share for such  
21 payments is required under federal law. For the period  
22 beginning June 10, 2012 through June 30, 2012, the annual  
23 assessment on outpatient services shall be prorated by  
24 multiplying the assessment amount by a fraction, the numerator  
25 of which is 21 days and the denominator of which is 365 days.  
26 For the period of April through June 2015, the amount of

1 .008766 used to calculate the assessment under this paragraph  
2 shall, by emergency rule under subsection (s) of Section 5-45  
3 of the Illinois Administrative Procedure Act, be increased by  
4 a uniform percentage to generate \$6,750,000 in the aggregate  
5 for that period from all hospitals subject to the annual  
6 assessment under this paragraph.

7 (2) In addition to any other assessments imposed under  
8 this Article, effective July 1, 2016 and semi-annually  
9 thereafter through June 2018, in addition to any federally  
10 required State share as authorized under paragraph (1), the  
11 amount of .008766 shall be increased by a uniform percentage  
12 to generate an amount equal to 25% of the ACA Assessment  
13 Adjustment, as defined in subsection (b-6) of this Section.

14 For the portion of State fiscal year 2012, beginning June  
15 10, 2012 through June 30, 2012, and State fiscal years 2013  
16 through 2018, or as provided in Section 5A-16, a hospital's  
17 outpatient gross revenue shall be determined using the most  
18 recent data available from each hospital's 2009 Medicare cost  
19 report as contained in the Healthcare Cost Report Information  
20 System file, for the quarter ending on June 30, 2011, without  
21 regard to any subsequent adjustments or changes to such data.  
22 If a hospital's 2009 Medicare cost report is not contained in  
23 the Healthcare Cost Report Information System, then the  
24 Department may obtain the hospital provider's outpatient gross  
25 revenue from any source available, including, but not limited  
26 to, records maintained by the hospital provider, which may be

1 inspected at all times during business hours of the day by the  
2 Department or its duly authorized agents and employees.

3 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State  
4 fiscal years 2019 and 2020, an annual assessment on outpatient  
5 services is imposed on each hospital provider in an amount  
6 equal to .01358 multiplied by the hospital's outpatient gross  
7 revenue. For State fiscal years 2019 and 2020, a hospital's  
8 outpatient gross revenue shall be determined using the most  
9 recent data available from each hospital's 2015 Medicare cost  
10 report as contained in the Healthcare Cost Report Information  
11 System file, for the quarter ending on March 31, 2017, without  
12 regard to any subsequent adjustments or changes to such data.  
13 If a hospital's 2015 Medicare cost report is not contained in  
14 the Healthcare Cost Report Information System, then the  
15 Department may obtain the hospital provider's outpatient gross  
16 revenue from any source available, including, but not limited  
17 to, records maintained by the hospital provider, which may be  
18 inspected at all times during business hours of the day by the  
19 Department or its duly authorized agents and employees.  
20 Notwithstanding any other provision in this Article, for a  
21 hospital provider that did not have a 2015 Medicare cost  
22 report, but paid an assessment in State fiscal year 2018 on the  
23 basis of hypothetical data, that assessment amount shall be  
24 used for State fiscal years 2019 and 2020.

25 (4) Subject to Sections 5A-3 and 5A-10 and to subsection  
26 (b-8), for the period of July 1, 2020 through December 31, 2020

1 and calendar years 2021 through 2026, an annual assessment on  
2 outpatient services is imposed on each hospital provider in an  
3 amount equal to .01525 multiplied by the hospital's outpatient  
4 gross revenue, provided however: (i) for the period of July 1,  
5 2020 through December 31, 2020, the assessment shall be equal  
6 to 50% of the annual amount; and (ii) the amount of .01525  
7 shall be retroactively adjusted by a uniform percentage to  
8 generate an amount equal to 50% of the Assessment Adjustment,  
9 as defined in subsection (b-7). For the period of July 1, 2020  
10 through December 31, 2020 and calendar years 2021 through  
11 2026, a hospital's outpatient gross revenue shall be  
12 determined using the most recent data available from each  
13 hospital's 2015 Medicare cost report as contained in the  
14 Healthcare Cost Report Information System file, for the  
15 quarter ending on March 31, 2017, without regard to any  
16 subsequent adjustments or changes to such data. If a  
17 hospital's 2015 Medicare cost report is not contained in the  
18 Healthcare Cost Report Information System, then the Illinois  
19 Department may obtain the hospital provider's outpatient  
20 revenue data from any source available, including, but not  
21 limited to, records maintained by the hospital provider, which  
22 may be inspected at all times during business hours of the day  
23 by the Illinois Department or its duly authorized agents and  
24 employees. Should the change in the assessment methodology  
25 above for fiscal years 2021 through calendar year 2022 not be  
26 approved prior to July 1, 2020, the assessment and payments

1 under this Article in effect for fiscal year 2020 shall remain  
2 in place until the new assessment is approved. If the change in  
3 the assessment methodology above for July 1, 2020 through  
4 December 31, 2022, is approved after June 30, 2020, it shall  
5 have a retroactive effective date of July 1, 2020, subject to  
6 federal approval and provided that the payments authorized  
7 under Section 12A-7 have the same effective date as the new  
8 assessment methodology. In giving retroactive effect to the  
9 assessment approved after June 30, 2020, credit toward the new  
10 assessment shall be given for any payments of the previous  
11 assessment for periods after June 30, 2020. Notwithstanding  
12 any other provision of this Article, for a hospital provider  
13 that did not have a 2015 Medicare cost report, but paid an  
14 assessment in State Fiscal Year 2020 on the basis of  
15 hypothetical data, the data that was the basis for the 2020  
16 assessment shall be used to calculate the assessment under  
17 this paragraph until December 31, 2023. Beginning July 1, 2022  
18 and through December 31, 2024, a safety-net hospital that had  
19 a change of ownership in calendar year 2021, and whose  
20 inpatient utilization had decreased by 90% from the prior year  
21 and prior to the change of ownership, may be eligible to pay a  
22 tax based on hypothetical data based on a determination of  
23 financial distress by the Department.

24 (6) For calendar year 2026, and for each year thereafter  
25 in which a tax is imposed under this Section, the Department  
26 may seek to obtain a waiver from the federal Centers for

1 Medicare and Medicaid Services of the uniformity requirements  
2 in place for the tax imposed under this Section, provided that  
3 such waiver request does not risk the assessment imposed or  
4 payments authorized under this Section from continuing. Such  
5 uniformity requirements shall only be waived for  
6 not-for-profit hospitals operating as a freestanding cancer  
7 hospital that have contracted to provide services to members  
8 served by at least 50% of the managed care organizations  
9 contracted with the Department. Such tax rates imposed on a  
10 hospital shall be no more than 50% and no less than 25% of the  
11 tax imposed on all other hospitals in this State unless  
12 different rates are necessary to meet federal statistical  
13 tests necessary for continued federal financial participation.  
14 Upon federal approval of such a waiver, other tax rates  
15 imposed under this Article shall be adjusted to ensure budget  
16 neutrality.

17 (b-6) (1) As used in this Section, "ACA Assessment  
18 Adjustment" means:

19 (A) For the period of July 1, 2016 through December  
20 31, 2016, the product of .19125 multiplied by the sum of  
21 the fee-for-service payments to hospitals as authorized  
22 under Section 5A-12.5 and the adjustments authorized under  
23 subsection (t) of Section 5A-12.2 to managed care  
24 organizations for hospital services due and payable in the  
25 month of April 2016 multiplied by 6.

26 (B) For the period of January 1, 2017 through June 30,

1           2017, the product of .19125 multiplied by the sum of the  
2           fee-for-service payments to hospitals as authorized under  
3           Section 5A-12.5 and the adjustments authorized under  
4           subsection (t) of Section 5A-12.2 to managed care  
5           organizations for hospital services due and payable in the  
6           month of October 2016 multiplied by 6, except that the  
7           amount calculated under this subparagraph (B) shall be  
8           adjusted, either positively or negatively, to account for  
9           the difference between the actual payments issued under  
10          Section 5A-12.5 for the period beginning July 1, 2016  
11          through December 31, 2016 and the estimated payments due  
12          and payable in the month of April 2016 multiplied by 6 as  
13          described in subparagraph (A).

14           (C) For the period of July 1, 2017 through December  
15          31, 2017, the product of .19125 multiplied by the sum of  
16          the fee-for-service payments to hospitals as authorized  
17          under Section 5A-12.5 and the adjustments authorized under  
18          subsection (t) of Section 5A-12.2 to managed care  
19          organizations for hospital services due and payable in the  
20          month of April 2017 multiplied by 6, except that the  
21          amount calculated under this subparagraph (C) shall be  
22          adjusted, either positively or negatively, to account for  
23          the difference between the actual payments issued under  
24          Section 5A-12.5 for the period beginning January 1, 2017  
25          through June 30, 2017 and the estimated payments due and  
26          payable in the month of October 2016 multiplied by 6 as

1 described in subparagraph (B).

2 (D) For the period of January 1, 2018 through June 30,  
3 2018, the product of .19125 multiplied by the sum of the  
4 fee-for-service payments to hospitals as authorized under  
5 Section 5A-12.5 and the adjustments authorized under  
6 subsection (t) of Section 5A-12.2 to managed care  
7 organizations for hospital services due and payable in the  
8 month of October 2017 multiplied by 6, except that:

9 (i) the amount calculated under this subparagraph

10 (D) shall be adjusted, either positively or  
11 negatively, to account for the difference between the  
12 actual payments issued under Section 5A-12.5 for the  
13 period of July 1, 2017 through December 31, 2017 and  
14 the estimated payments due and payable in the month of  
15 April 2017 multiplied by 6 as described in  
16 subparagraph (C); and

17 (ii) the amount calculated under this subparagraph  
18 (D) shall be adjusted to include the product of .19125  
19 multiplied by the sum of the fee-for-service payments,  
20 if any, estimated to be paid to hospitals under  
21 subsection (b) of Section 5A-12.5.

22 (2) The Department shall complete and apply a final  
23 reconciliation of the ACA Assessment Adjustment prior to June  
24 30, 2018 to account for:

25 (A) any differences between the actual payments issued  
26 or scheduled to be issued prior to June 30, 2018 as

1 authorized in Section 5A-12.5 for the period of January 1,  
2 2018 through June 30, 2018 and the estimated payments due  
3 and payable in the month of October 2017 multiplied by 6 as  
4 described in subparagraph (D); and

5 (B) any difference between the estimated  
6 fee-for-service payments under subsection (b) of Section  
7 5A-12.5 and the amount of such payments that are actually  
8 scheduled to be paid.

9 The Department shall notify hospitals of any additional  
10 amounts owed or reduction credits to be applied to the June  
11 2018 ACA Assessment Adjustment. This is to be considered the  
12 final reconciliation for the ACA Assessment Adjustment.

13 (3) Notwithstanding any other provision of this Section,  
14 if for any reason the scheduled payments under subsection (b)  
15 of Section 5A-12.5 are not issued in full by the final day of  
16 the period authorized under subsection (b) of Section 5A-12.5,  
17 funds collected from each hospital pursuant to subparagraph  
18 (D) of paragraph (1) and pursuant to paragraph (2),  
19 attributable to the scheduled payments authorized under  
20 subsection (b) of Section 5A-12.5 that are not issued in full  
21 by the final day of the period attributable to each payment  
22 authorized under subsection (b) of Section 5A-12.5, shall be  
23 refunded.

24 (4) The increases authorized under paragraph (2) of  
25 subsection (a) and paragraph (2) of subsection (b-5) shall be  
26 limited to the federally required State share of the total

1 payments authorized under Section 5A-12.5 if the sum of such  
2 payments yields an annualized amount equal to or less than  
3 \$450,000,000, or if the adjustments authorized under  
4 subsection (t) of Section 5A-12.2 are found not to be  
5 actuarially sound; however, this limitation shall not apply to  
6 the fee-for-service payments described in subsection (b) of  
7 Section 5A-12.5.

8 (b-7) (1) As used in this Section, "Assessment Adjustment"  
9 means:

10 (A) For the period of July 1, 2020 through December  
11 31, 2020, the product of .3853 multiplied by the total of  
12 the actual payments made under subsections (c) through (k)  
13 of Section 5A-12.7 attributable to the period, less the  
14 total of the assessment imposed under subsections (a) and  
15 (b-5) of this Section for the period.

16 (B) For each calendar quarter beginning January 1,  
17 2021 through December 31, 2022, the product of .3853  
18 multiplied by the total of the actual payments made under  
19 subsections (c) through (k) of Section 5A-12.7  
20 attributable to the period, less the total of the  
21 assessment imposed under subsections (a) and (b-5) of this  
22 Section for the period.

23 (C) Beginning on January 1, 2023, and each subsequent  
24 July 1 and January 1, the product of .3853 multiplied by  
25 the total of the actual payments made under subsections  
26 (c) through (j) of Section 5A-12.7 attributable to the

1           6-month period immediately preceding the period to which  
2           the adjustment applies, less the total of the assessment  
3           imposed under subsections (a) and (b-5) of this Section  
4           for the 6-month period immediately preceding the period to  
5           which the adjustment applies.

6           (2) The Department shall calculate and notify each  
7           hospital of the total Assessment Adjustment and any additional  
8           assessment owed by the hospital or refund owed to the hospital  
9           on either a semi-annual or annual basis. Such notice shall be  
10          issued at least 30 days prior to any period in which the  
11          assessment will be adjusted. Any additional assessment owed by  
12          the hospital or refund owed to the hospital shall be uniformly  
13          applied to the assessment owed by the hospital in monthly  
14          installments for the subsequent semi-annual period or calendar  
15          year. If no assessment is owed in the subsequent year, any  
16          amount owed by the hospital or refund due to the hospital,  
17          shall be paid in a lump sum.

18          (3) The Department shall publish all details of the  
19          Assessment Adjustment calculation performed each year on its  
20          website within 30 days of completing the calculation, and also  
21          submit the details of the Assessment Adjustment calculation as  
22          part of the Department's annual report to the General  
23          Assembly.

24          (b-8) Notwithstanding any other provision of this Article,  
25          the Department shall reduce the assessments imposed on each  
26          hospital under subsections (a) and (b-5) by the uniform

1 percentage necessary to reduce the total assessment imposed on  
2 all hospitals by an aggregate amount of \$240,000,000, with  
3 such reduction being applied by June 30, 2022. The assessment  
4 reduction required for each hospital under this subsection  
5 shall be forever waived, forgiven, and released by the  
6 Department.

7 (c) (Blank).

8 (d) Notwithstanding any of the other provisions of this  
9 Section, the Department is authorized to adopt rules to reduce  
10 the rate of any annual assessment imposed under this Section,  
11 as authorized by Section 5-46.2 of the Illinois Administrative  
12 Procedure Act.

13 (e) Notwithstanding any other provision of this Section,  
14 any plan providing for an assessment on a hospital provider as  
15 a permissible tax under Title XIX of the federal Social  
16 Security Act and Medicaid-eligible payments to hospital  
17 providers from the revenues derived from that assessment shall  
18 be reviewed by the Illinois Department of Healthcare and  
19 Family Services, as the Single State Medicaid Agency required  
20 by federal law, to determine whether those assessments and  
21 hospital provider payments meet federal Medicaid standards. If  
22 the Department determines that the elements of the plan may  
23 meet federal Medicaid standards and a related State Medicaid  
24 Plan Amendment is prepared in a manner and form suitable for  
25 submission, that State Plan Amendment shall be submitted in a  
26 timely manner for review by the Centers for Medicare and

1 Medicaid Services of the United States Department of Health  
2 and Human Services and subject to approval by the Centers for  
3 Medicare and Medicaid Services of the United States Department  
4 of Health and Human Services. No such plan shall become  
5 effective without approval by the Illinois General Assembly by  
6 the enactment into law of related legislation. Notwithstanding  
7 any other provision of this Section, the Department is  
8 authorized to adopt rules to reduce the rate of any annual  
9 assessment imposed under this Section. Any such rules may be  
10 adopted by the Department under Section 5-50 of the Illinois  
11 Administrative Procedure Act.

12 (Source: P.A. 102-886, eff. 5-17-22; 103-102, eff. 1-1-24.)

13 ARTICLE 800.

14 Section 800-95. No acceleration or delay. Where this Act  
15 makes changes in a statute that is represented in this Act by  
16 text that is not yet or no longer in effect (for example, a  
17 Section represented by multiple versions), the use of that  
18 text does not accelerate or delay the taking effect of (i) the  
19 changes made by this Act or (ii) provisions derived from any  
20 other Public Act.

21 ARTICLE 999.

22 Section 999-99. Effective date. This Act takes effect upon  
23 becoming law, except that Article 10 takes effect January 1,

SB2437 Enrolled

- 231 -

LRB104 10548 KTG 20624 b

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