Rep. Gregory Harris

Filed: 5/21/2020

AMENDMENT TO SENATE BILL 1864

AMENDMENT NO. _____. Amend Senate Bill 1864 by replacing everything after the enacting clause with the following:

"Article 5. Health Care Affordability Act

Section 5-1. Short title. This Article may be cited as the Health Care Affordability Act. References in this Article to "this Act" mean this Article.

Section 5-5. Findings. The General Assembly finds that:

(1) The State is committed to improving the health and well-being of Illinois residents and families.

(2) Illinois has over 835,000 uninsured residents, with a total uninsured rate of 7.9%.

(3) 774,500 of Illinois' uninsured residents are below 400% of the federal poverty level, with higher uninsured rates of more than 13% below 250% of the federal poverty

level and an uninsured rate of 8.3% below 400% of the federal poverty level.

(4) The cost of health insurance premiums remains a barrier to obtaining health insurance coverage for many Illinois residents and families.

(5) Many Illinois residents and families who have health insurance cannot afford to use it due to high deductibles and cost sharing.

(6) Improving health insurance affordability is key to increasing health insurance coverage and access.

(7) Despite progress made under the Patient Protection and Affordable Care Act, health insurance is still not affordable enough for many Illinois residents and families.

(8) Illinois has a lower uninsured rate than the national average of 10.2%, but a higher uninsured rate compared to states that have state-directed policies to improve affordability, including Massachusetts with an uninsured rate of 3.2%.

(9) Illinois has an opportunity to create a healthy Illinois where health insurance coverage is more affordable and accessible for all Illinois residents, families, and small businesses.

Section 5-10. Feasibility study.

(a) The Department of Healthcare and Family Services, in

consultation with the Department of Insurance, shall oversee a feasibility study to explore options to make health insurance more affordable for low-income and middle-income residents. The study shall include policies targeted at increasing health care affordability and access, including policies being discussed in other states and nationally. The study shall follow the best practices of other states and include an Illinois-specific actuarial and economic analysis of demographic and market dynamics.

(b) The study shall produce cost estimates for the policies studied under subsection (a) along with the impact of the policies on health insurance affordability and access and the uninsured rates for low-income and middle-income residents, with break-out data by geography, race, ethnicity, and income level. The study shall evaluate how multiple policies implemented together affect costs and outcomes and how policies could be structured to leverage federal matching funds and federal pass-through awards.

(c) The Department of Healthcare and Family Services, in consultation with the Department of Insurance, shall develop and submit no later than February 28, 2021 a report to the General Assembly and the Governor concerning the design, costs, benefits, and implementation of State options to increase access to affordable health care coverage that leverage existing State infrastructure.

Article 10. Kidney Disease Prevention and Education Task Force Act

Section 10-1. Short title. This Article may be cited as the Kidney Disease Prevention and Education Task Force Act. References in this Article to "this Act" mean this Article.

Section 10-5. Findings. The General Assembly finds that:

(1) Chronic kidney disease is the 9th-leading cause of death in the United States. An estimated 31 million people in the United States have chronic kidney disease and over 1.12 million people in the State of Illinois are living with the disease. Early chronic kidney disease has no signs or symptoms and, without early detection, can progress to kidney failure.

(2) If a person has high blood pressure, heart disease, diabetes, or a family history of kidney failure, the risk of kidney disease is greater. In Illinois, 13% of all adults have diabetes, and 32% have high blood pressure. The prevalence of diabetes, heart disease, and hypertension is higher for African Americans, who develop kidney failure at a rate of nearly 4 to 1 compared to Caucasians, while Hispanics develop kidney failure at a rate of 2 to 1. Almost half of the people waiting for a kidney in Illinois identify as African American, but, in 2017, less than 10% of them received a kidney.

(3) Although dialysis is a life-extending treatment, the best and most cost-effective treatment for kidney failure is a kidney transplant. Currently, the wait in Illinois for a deceased donor kidney is 5-7 years, and 13 people die while waiting every day.

(4) If chronic kidney disease is detected early and managed appropriately, the individual can receive treatment sooner to help protect the kidneys, the deterioration in kidney function can be slowed or even stopped, and the risk of associated cardiovascular complications and other complications can be reduced.

(5) In light of the COVID-19 pandemic and the increased risk of infection to patients with preexisting conditions, it is imperative to provide those with kidney disease with support.

Section 10-10. Kidney Disease Prevention and Education Task Force.

(a) There is hereby established the Kidney Disease Prevention and Education Task Force to work directly with educational institutions to create health education programs to increase awareness of and to examine chronic kidney disease, transplantations, living and deceased kidney donation, and the existing disparity in the rates of those afflicted between Caucasians and minorities.

(b) The Task Force shall develop a sustainable plan to

raise awareness about early detection, promote health equity, and reduce the burden of kidney disease throughout the State, which shall include an ongoing campaign that includes health education workshops and seminars, relevant research, and preventive screenings and that promotes social media campaigns and TV and radio commercials.

(c) Membership of the Task Force shall be as follows:

(1) one member of the Senate, appointed by the Senate President, who shall serve as Co-Chair;

(2) one member of the House of Representatives, appointed by the Speaker of the House, who shall serve as Co-Chair;

(3) one member of the House of Representatives, appointed by the Minority Leader of the House;

(4) one member of the Senate, appointed by the Senate Minority Leader;

(5) one member representing the Department of Public Health, appointed by the Governor;

(6) one member representing the Department of Healthcare and Family Services, appointed by the Governor;

(7) one member representing a medical center in a county with a population of more 3 million residents, appointed by the Co-Chairs;

(8) one member representing a physician's association in a county with a population of more than 3 million residents, appointed by the Co-Chairs;

(9) one member representing a not-for-profit organ procurement organization, appointed by the Co-Chairs;

(10) one member representing a national nonprofit research kidney organization in the State of Illinois, appointed by the Co-Chairs; and

(11) the Secretary of State or his or her designee.

(d) Members of the Task Force shall serve without compensation.

(e) The Department of Public Health shall provide administrative support to the Task Force.

(f) The Task Force shall submit its final report to the General Assembly on or before December 31, 2021 and, upon the filing of its final report, is dissolved.

Section 10-15. Repeal. This Act is repealed on June 1, 2022.

Article 15. Telehealth During the COVID-19 Pandemic Act

Section 15-1. Short title. This Article may be cited as the Telehealth During the COVID-19 Pandemic Act. References in this Article to "this Act" mean this Article.

Section 15-5. Applicability.

(a) This Act does not apply to excepted benefits as defined in 45 CFR 146.145(b) and 45 CFR. 148.220 but does apply to

limited scope dental benefits, limited scope vision benefits, long-term care benefits, coverage only for accidents, or coverage only for specified disease or illness.

(b) This Act applies to short-term, limited-duration health insurance coverage; fully insured student health insurance coverage; and fully insured association health plans except with respect to excepted benefits.

(c) Any policy, contract, or certificate of health insurance coverage that does not distinguish between in-network and out-of-network providers shall be subject to this Act as though all providers were in-network.

Section 15-10. Definitions. As used in this Act:

"Health insurance coverage" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Health insurance issuer" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Telehealth services" means the provision of health care, psychiatry, mental health treatment, substance use disorder treatment, and related services to a patient, regardless of his or her location, through electronic or telephonic methods, such as telephone (landline or cellular), video technology commonly available on smart phones and other devices, and videoconferencing, as well as any method within the meaning of

telehealth services under Section 356z.22 of the Illinois Insurance Code.

Section 15-15. Coverage for telehealth services during the COVID-19 pandemic.

(a) In order to protect the public's health, to permit expedited treatment of health conditions during the COVID-19 pandemic, and to mitigate its impact upon the residents of the State of Illinois, all health insurance issuers regulated by the Department of Insurance shall cover the costs of all telehealth services rendered by in-network providers to deliver any clinically appropriate, medically necessary covered services and treatments to insureds, enrollees, and members under each policy, contract, or certificate of health insurance coverage.

(b) Health insurance issuers may establish reasonable requirements and parameters for telehealth services, including with respect to documentation and recordkeeping, to the extent consistent with this Act or any company bulletin subsequently issued by the Department of Insurance under Executive Order 2020-09. A health insurance issuer's requirements and parameters may not be more restrictive or less favorable toward providers, insureds, enrollees, or members than those contained in the emergency rulemaking undertaken by the Department of Healthcare and Family Services at 89 Ill. Adm. Code 140.403(e). Health insurance issuers shall notify

providers of any instructions necessary to facilitate billing for telehealth services.

Section 15-20. Prior authorization and utilization review requirements.

(a) In order to ensure that health care is quickly and efficiently provided to the public, health insurance issuers shall not impose upon telehealth services utilization review requirements that are unnecessary, duplicative, or unwarranted nor impose any treatment limitations that are more stringent than the requirements applicable to the same health care service when rendered in-person.

(b) For telehealth services that relate to COVID-19 delivered by in-network providers, health insurance issuers shall not impose any prior authorization requirements.

Section 15-25. Cost-sharing prohibited. Health insurance issuers shall not impose any cost-sharing (copayments, deductibles, or coinsurance) for telehealth services provided by in-network providers. However, in accordance with the standards and definitions in 26 U.S.C. 223, if an enrollee in a high-deductible health plan has not met the applicable deductible under the terms of his or her coverage, the requirements of this Section do not require an issuer to pay for a charge for telehealth services unless the associated health care service for that particular charge is deemed

preventive care by the United States Department of the Treasury. The federal Internal Revenue Service has recognized that services for testing, treatment, and any potential vaccination for COVID-19 fall within the scope of preventive care.

Section 15-30. Eligible services. Services eligible under this Act include services provided by any professional, practitioner, clinician, or other provider who is licensed, certified, registered, or otherwise authorized to practice in the State where the patient receives treatment, subject to the provisions of the Telehealth Act for any health care professional, as defined in the Telehealth Act, who delivers treatment through telehealth to a patient located in this State, and substance use disorder professionals and clinicians authorized by Illinois law to provide substance use disorder services.

Section 15-35. Mental Health and Developmental Disabilities Confidentiality Act. A covered health care provider or covered entity subject to the requirements of the Mental Health and Developmental Disabilities Confidentiality Act that uses audio or video communication technology to provide telehealth services to mental health and developmental disability patients may use any non-public facing remote communication product in accordance with this Act for the

duration of the Gubernatorial Disaster Proclamation issued by the Governor on March 9, 2020 concerning COVID-19 and any subsequent Gubernatorial Disaster Proclamation issued by the Governor concerning COVID-19. Providers and covered entities shall, to the extent feasible, notify patients that third-party applications potentially introduce privacy risks. Providers shall enable all available encryption and privacy modes when using such applications. A public facing video communication application may not be used in the provision of telehealth services by covered health care providers or covered entities.

Section 15-40. Rulemaking authority. The Department of Insurance may adopt rules to implement the provisions of this Act.

Section 15-90. Repeal. This Act is repealed on May 1, 2021.

Article 90. Amendatory Provisions

Section 90-5. The Freedom of Information Act is amended by changing Section 7.5 as follows:

(5 ILCS 140/7.5)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(n) Defense budgets and petitions for certification of

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

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

(p) Security portions of system safety program plans, investigation reports, surveys, schedules, lists, data, or information compiled, collected, or prepared by or for the Regional Transportation Authority under Section 2.11 of the Regional Transportation Authority Act or the St. Clair County Transit District under the Bi-State Transit Safety Act.

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

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

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

(t) All identified or deidentified health information in the form of health data or medical records contained in, stored in, submitted to, transferred by, or released from the Illinois Health Information Exchange, and identified

or deidentified health information in the form of health data and medical records of the Illinois Health Information Exchange in the possession of the Illinois Health Information Exchange Office ~~Authority~~ due to its administration of the Illinois Health Information Exchange. The terms "identified" and "deidentified" shall be given the same meaning as in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, or any subsequent amendments thereto, and any regulations promulgated thereunder.

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

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

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

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

(y) Confidential information under the Adult Protective Services Act and its predecessor enabling statute, the Elder Abuse and Neglect Act, including information about the identity and administrative finding against any caregiver of a verified and substantiated decision of abuse, neglect, or financial exploitation of an eligible adult maintained in the Registry established under Section 7.5 of the Adult Protective Services Act.

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

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

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

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

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

(ee) Information that is exempted from disclosure

under Section 30.1 of the Pharmacy Practice Act.

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

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

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

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

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

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

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

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

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

(oo) Communications, notes, records, and reports

arising out of a peer support counseling session prohibited from disclosure under the First Responders Suicide Prevention Act.

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

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

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

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

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

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

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

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

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

Illinois Insurance Code.

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

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

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

(Source: P.A. 100-20, eff. 7-1-17; 100-22, eff. 1-1-18; 100-201, eff. 8-18-17; 100-373, eff. 1-1-18; 100-464, eff. 8-28-17; 100-465, eff. 8-31-17; 100-512, eff. 7-1-18; 100-517, eff. 6-1-18; 100-646, eff. 7-27-18; 100-690, eff. 1-1-19; 100-863, eff. 8-14-18; 100-887, eff. 8-14-18; 101-13, eff. 6-12-19; 101-27, eff. 6-25-19; 101-81, eff. 7-12-19; 101-221, eff. 1-1-20; 101-236, eff. 1-1-20; 101-375, eff. 8-16-19; 101-377, eff. 8-16-19; 101-452, eff. 1-1-20; 101-466, eff. 1-1-20; 101-600, eff. 12-6-19; 101-620, eff 12-20-19; revised 1-6-20.)

Section 90-10. The Illinois Health Information Exchange and Technology Act is amended by changing Sections 10, 20, 25, 30, 35, and 40, as follows:

(20 ILCS 3860/10)

(Section scheduled to be repealed on January 1, 2021)

Sec. 10. Creation of the Health Information Exchange Office ~~Authority~~. There is hereby created the Illinois Health

Information Exchange Office ("Office") ~~Authority ("Authority")~~, which is hereby constituted as an instrumentality and an administrative agency of the State of Illinois.

As part of its program to promote, develop, and sustain health information exchange at the State level, the Office ~~Authority~~ shall do the following:

(1) Establish the Illinois Health Information Exchange ("ILHIE"), to promote and facilitate the sharing of health information among health care providers within Illinois and in other states. ILHIE shall be an entity operated by the Office ~~Authority~~ to serve as a State-level electronic medical records exchange providing for the transfer of health information, medical records, and other health data in a secure environment for the benefit of patient care, patient safety, reduction of duplicate medical tests, reduction of administrative costs, and any other benefits deemed appropriate by the Office ~~Authority~~.

(2) Foster the widespread adoption of electronic health records and participation in the ILHIE.

(Source: P.A. 96-1331, eff. 7-27-10.)

(20 ILCS 3860/20)

(Section scheduled to be repealed on January 1, 2021)

Sec. 20. Powers and duties of the Illinois Health Information Exchange Office ~~Authority~~. The Office ~~Authority~~

has the following powers, together with all powers incidental or necessary to accomplish the purposes of this Act:

(1) The Office ~~Authority~~ shall create and administer the ILHIE using information systems and processes that are secure, are cost effective, and meet all other relevant privacy and security requirements under State and federal law.

(2) The Office ~~Authority~~ shall establish and adopt standards and requirements for the use of health information and the requirements for participation in the ILHIE by persons or entities including, but not limited to, health care providers, payors, and local health information exchanges.

(3) The Office ~~Authority~~ shall establish minimum standards for accessing the ILHIE to ensure that the appropriate security and privacy protections apply to health information, consistent with applicable federal and State standards and laws. The Office ~~Authority~~ shall have the power to suspend, limit, or terminate the right to participate in the ILHIE for non-compliance or failure to act, with respect to applicable standards and laws, in the best interests of patients, users of the ILHIE, or the public. The Office ~~Authority~~ may seek all remedies allowed by law to address any violation of the terms of participation in the ILHIE.

(4) The Office ~~Authority~~ shall identify barriers to the

adoption of electronic health records systems, including researching the rates and patterns of dissemination and use of electronic health record systems throughout the State. The Office ~~Authority~~ shall make the results of the research available on the Department of Healthcare and Family Services' website ~~its website~~.

(5) The Office ~~Authority~~ shall prepare educational materials and educate the general public on the benefits of electronic health records, the ILHIE, and the safeguards available to prevent unauthorized disclosure of health information.

(6) The Office ~~Authority~~ may appoint or designate an institutional review board in accordance with federal and State law to review and approve requests for research in order to ensure compliance with standards and patient privacy and security protections as specified in paragraph (3) of this Section.

(7) The Office ~~Authority~~ may enter into all contracts and agreements necessary or incidental to the performance of its powers under this Act. The Office's ~~Authority's~~ expenditures of private funds are exempt from the Illinois Procurement Code, pursuant to Section 1-10 of that Act. Notwithstanding this exception, the Office ~~Authority~~ shall comply with the Business Enterprise for Minorities, Women, and Persons with Disabilities Act.

(8) The Office ~~Authority~~ may solicit and accept grants,

loans, contributions, or appropriations from any public or private source and may expend those moneys, through contracts, grants, loans, or agreements, on activities it considers suitable to the performance of its duties under this Act.

(9) The Office ~~Authority~~ may determine, charge, and collect any fees, charges, costs, and expenses from any healthcare provider or entity in connection with its duties under this Act. Moneys collected under this paragraph (9) shall be deposited into the Health Information Exchange Fund.

(10) The Office ~~Authority~~ may~~, under the direction of the Executive Director,~~ employ and discharge staff, including administrative, technical, expert, professional, and legal staff, as is necessary or convenient to carry out the purposes of this Act and as authorized by the Personnel Code. ~~The Authority may establish and administer standards of classification regarding compensation, benefits, duties, performance, and tenure for that staff and may enter into contracts of employment with members of that staff for such periods and on such terms as the Authority deems desirable. All employees of the Authority are exempt from the Personnel Code as provided by Section 4 of the Personnel Code.~~

(10.5) Staff employed by the Illinois Health Information Exchange Authority on the effective date of

this amendatory Act of the 101st General Assembly shall transfer to the Office within the Department of Healthcare and Family Services.

(10.6) The status and rights of employees transferring from the Illinois Health Information Exchange Authority under paragraph (10.5) shall not be affected by such transfer except that, notwithstanding any other State law to the contrary, those employees shall maintain their seniority and their positions shall convert to titles of comparable organizational level under the Personnel Code and become subject to the Personnel Code. Other than the changes described in this paragraph, the rights of employees, the State of Illinois, and State agencies under the Personnel Code or under any pension, retirement, or annuity plan shall not be affected by this amendatory Act of the 101st General Assembly. Transferring personnel shall continue their service within the Office.

(11) The Office ~~Authority~~ shall consult and coordinate with the Department of Public Health to further the Office's ~~Authority's~~ collection of health information from health care providers for public health purposes. The collection of public health information shall include identifiable information for use by the Office ~~Authority~~ or other State agencies to comply with State and federal laws. Any identifiable information so collected shall be privileged and confidential in accordance with Sections

8-2101, 8-2102, 8-2103, 8-2104, and 8-2105 of the Code of Civil Procedure.

(12) All identified or deidentified health information in the form of health data or medical records contained in, stored in, submitted to, transferred by, or released from the Illinois Health Information Exchange, and identified or deidentified health information in the form of health data and medical records of the Illinois Health Information Exchange in the possession of the Illinois Health Information Exchange Office ~~Authority~~ due to its administration of the Illinois Health Information Exchange, shall be exempt from inspection and copying under the Freedom of Information Act. The terms "identified" and "deidentified" shall be given the same meaning as in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, or any subsequent amendments thereto, and any regulations promulgated thereunder.

(13) To address gaps in the adoption of, workforce preparation for, and exchange of electronic health records that result in regional and socioeconomic disparities in the delivery of care, the Office ~~Authority~~ may evaluate such gaps and provide resources as available, giving priority to healthcare providers serving a significant percentage of Medicaid or uninsured patients and in medically underserved or rural areas.

(14) The Office shall perform its duties under this Act

in consultation with the Office of the Governor and with the Departments of Public Health, Insurance, and Human Services.

(Source: P.A. 99-642, eff. 7-28-16; 100-391, eff. 8-25-17.)

(20 ILCS 3860/25)

(Section scheduled to be repealed on January 1, 2021)

Sec. 25. Health Information Exchange Fund.

(a) The Health Information Exchange Fund (the "Fund") is created as a separate fund outside the State treasury. Moneys in the Fund are not subject to appropriation by the General Assembly. The State Treasurer shall be ex-officio custodian of the Fund. Revenues arising from the operation and administration of the Office ~~Authority~~ and the ILHIE shall be deposited into the Fund. Fees, charges, State and federal moneys, grants, donations, gifts, interest, or other moneys shall be deposited into the Fund. "Private funds" means gifts, donations, and private grants.

(b) The Office ~~Authority~~ is authorized to spend moneys in the Fund on activities suitable to the performance of its duties as provided in Section 20 of this Act and authorized by this Act. Disbursements may be made from the Fund for purposes related to the operations and functions of the Office ~~Authority~~ and the ILHIE.

(c) The Illinois General Assembly may appropriate moneys to the Office ~~Authority~~ and the ILHIE, and those moneys shall be

deposited into the Fund.

(d) The Fund is not subject to administrative charges or charge-backs, including but not limited to those authorized under Section 8h of the State Finance Act.

(e) The Office's ~~Authority's~~ accounts and books shall be set up and maintained in accordance with the Office of the Comptroller's requirements, and the ~~Authority's Executive~~ Director of the Department of Healthcare and Family Services shall be responsible for the approval of recording of receipts, approval of payments, and proper filing of required reports. The moneys held and made available by the Office ~~Authority~~ shall be subject to financial and compliance audits by the Auditor General in compliance with the Illinois State Auditing Act.

(Source: P.A. 96-1331, eff. 7-27-10.)

(20 ILCS 3860/30)

(Section scheduled to be repealed on January 1, 2021)

Sec. 30. Participation in health information systems maintained by State agencies.

(a) By no later than January 1, 2015, each State agency that implements, acquires, or upgrades health information technology systems shall use health information technology systems and products that meet minimum standards adopted by the Office ~~Authority~~ for accessing the ILHIE. State agencies that have health information which supports and develops the ILHIE

shall provide access to patient-specific data to complete the patient record at the ILHIE. Notwithstanding any other provision of State law, the State agencies shall provide patient-specific data to the ILHIE.

(b) Participation in the ILHIE shall have no impact on the content of or use or disclosure of health information of patient participants that is held in locations other than the ILHIE. Nothing in this Act shall limit or change an entity's obligation to exchange health information in accordance with applicable federal and State laws and standards.

(Source: P.A. 96-1331, eff. 7-27-10.)

(20 ILCS 3860/35)

(Section scheduled to be repealed on January 1, 2021)

Sec. 35. Illinois Administrative Procedure Act. The provisions of the Illinois Administrative Procedure Act are hereby expressly adopted and shall apply to all administrative rules and procedures of the Office ~~Authority~~, except that Section 5-35 of the Illinois Administrative Procedure Act relating to procedures for rulemaking does not apply to the adoption of any rule required by federal law when the Office ~~Authority~~ is precluded by that law from exercising any discretion regarding that rule.

(Source: P.A. 96-1331, eff. 7-27-10.)

(20 ILCS 3860/40)

(Section scheduled to be repealed on January 1, 2021)

Sec. 40. Reliance on data. Any health care provider who relies in good faith upon any information provided through the ILHIE in his, her, or its treatment of a patient shall be immune from criminal or civil liability or professional discipline arising from any damages caused by such good faith reliance. This immunity does not apply to acts or omissions constituting gross negligence or reckless, wanton, or intentional misconduct. Notwithstanding this provision, the Office ~~Authority~~ does not waive any immunities provided under State or federal law.

(Source: P.A. 98-1046, eff. 1-1-15.)

(20 ILCS 3860/15 rep.)

Section 90-15. The Illinois Health Information Exchange and Technology Act is amended by repealing Section 15.

Section 90-20. The Children's Health Insurance Program Act is amended by changing Section 7 and by adding Section 8 as follows:

(215 ILCS 106/7)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that

complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By no later than July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants to the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub.

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data

obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. The Department shall send a notice to the recipient at least 60 days prior to the end of the period of eligibility that informs them of the requirements for continued eligibility. Information the Department receives prior to the annual review, including information available to the Department as a result of the recipient's application for other non-health care benefits, that is sufficient to make a determination of continued eligibility for medical assistance or for benefits provided under the Program may be reviewed and verified, and subsequent action taken including client notification of continued eligibility for medical assistance or for benefits provided under the Program. The date of client notification establishes the date for subsequent annual eligibility reviews. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall be issued to the recipient and coverage shall end no later than the last day of the month following the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for

continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By no later than July 1, 2011, require verification of Illinois residency.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data will be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility

verification.

(Source: P.A. 101-209, eff. 8-5-19.)

(215 ILCS 106/8 new)

Sec. 8. COVID-19 public health emergency. Notwithstanding any other provision of this Act, the Department may take necessary actions to address the COVID-19 public health emergency to the extent such actions are required, approved, or authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Such actions may continue throughout the public health emergency and for up to 12 months after the period ends, and may include, but are not limited to: accepting an applicant's or recipient's attestation of income, incurred medical expenses, residency, and insured status when electronic verification is not available; eliminating resource tests for some eligibility determinations; suspending redeterminations; suspending changes that would adversely affect an applicant's or recipient's eligibility; phone or verbal approval by an applicant to submit an application in lieu of applicant signature; allowing adult presumptive eligibility; allowing presumptive eligibility for children, pregnant women, and adults as often as twice per calendar year; paying for additional services delivered by telehealth; and suspending premium and co-payment requirements.

The Department's authority under this Section shall only

extend to encompass, incorporate, or effectuate the terms, items, conditions, and other provisions approved, authorized, or required by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, and shall not extend beyond the time of the COVID-19 public health emergency and up to 12 months after the period expires.

Section 90-25. The Covering ALL KIDS Health Insurance Act is amended by changing Section 7 and by adding Section 8 as follows:

(215 ILCS 170/7)

(Section scheduled to be repealed on October 1, 2024)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants to the Program.

Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub.

(2) By October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. Information the Department receives prior to the annual review, including information available to the

Department as a result of the recipient's application for other non-health care benefits, that is sufficient to make a determination of continued eligibility for benefits provided under this Act, the Children's Health Insurance Program Act, or Article V of the Illinois Public Aid Code may be reviewed and verified, and subsequent action taken including client notification of continued eligibility for benefits provided under this Act, the Children's Health Insurance Program Act, or Article V of the Illinois Public Aid Code. The date of client notification establishes the date for subsequent annual eligibility reviews. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall be issued to the recipient and coverage shall end no later than the last day of the month following the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By July 1, 2011, require verification of Illinois residency.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data will be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.

(Source: P.A. 101-209, eff. 8-5-19.)

(215 ILCS 170/8 new)

Sec. 8. COVID-19 public health emergency. Notwithstanding any other provision of this Act, the Department may take necessary actions to address the COVID-19 public health

emergency to the extent such actions are required, approved, or authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Such actions may continue throughout the public health emergency and for up to 12 months after the period ends, and may include, but are not limited to: accepting an applicant's or recipient's attestation of income, incurred medical expenses, residency, and insured status when electronic verification is not available; eliminating resource tests for some eligibility determinations; suspending redeterminations; suspending changes that would adversely affect an applicant's or recipient's eligibility; phone or verbal approval by an applicant to submit an application in lieu of applicant signature; allowing adult presumptive eligibility; allowing presumptive eligibility for children, pregnant women, and adults as often as twice per calendar year; paying for additional services delivered by telehealth; and suspending premium and co-payment requirements.

The Department's authority under this Section shall only extend to encompass, incorporate, or effectuate the terms, items, conditions, and other provisions approved, authorized, or required by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, and shall not extend beyond the time of the COVID-19 public health emergency and up to 12 months after the period expires.

Section 90-30. The Pharmacy Practice Act is amended by adding Section 39.5 as follows:

(225 ILCS 85/39.5 new)

Sec. 39.5. Emergency kits.

(a) As used in this Section:

"Emergency kit" means a kit containing drugs that may be required to meet the immediate therapeutic needs of a patient and that are not available from any other source in sufficient time to prevent the risk of harm to a patient by delay resulting from obtaining the drugs from another source. An automated dispensing and storage system may be used as an emergency kit.

"Licensed facility" means an entity licensed under the Nursing Home Care Act, the Hospital Licensing Act, or the University of Illinois Hospital Act or a facility licensed under the Illinois Department of Human Services, Division of Substance Use Prevention and Recovery, for the prevention, intervention, treatment, and recovery support of substance use disorders or certified by the Illinois Department of Human Services, Division of Mental Health for the treatment of mental health.

"Offsite institutional pharmacy" means: (1) a pharmacy that is not located in facilities it serves and whose primary purpose is to provide services to patients or residents of facilities licensed under the Nursing Home Care Act, the

Hospital Licensing Act, or the University of Illinois Hospital Act; and (2) a pharmacy that is not located in the facilities it serves and the facilities it serves are licensed under the Illinois Department of Human Services, Division of Substance Use Prevention and Recovery, for the prevention, intervention, treatment, and recovery support of substance use disorders or for the treatment of mental health.

(b) An offsite institutional pharmacy may supply emergency kits to a licensed facility.

Section 90-33. The Telehealth Act is amended by changing Section 5 as follows:

(225 ILCS 150/5)

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

"Health care professional" includes physicians, physician assistants, optometrists, advanced practice registered nurses, clinical psychologists licensed in Illinois, prescribing psychologists licensed in Illinois, dentists, occupational therapists, pharmacists, physical therapists, clinical social workers, speech-language pathologists, audiologists, hearing instrument dispensers, substance use disorder professionals and clinicians, and mental health professionals and clinicians authorized by Illinois law to provide mental health services.

"Telehealth" means the evaluation, diagnosis, or interpretation of electronically transmitted patient-specific

data between a remote location and a licensed health care professional that generates interaction or treatment recommendations. "Telehealth" includes telemedicine and the delivery of health care services provided by way of an interactive telecommunications system, as defined in subsection (a) of Section 356z.22 of the Illinois Insurance Code.

(Source: P.A. 100-317, eff. 1-1-18; 100-644, eff. 1-1-19; 100-930, eff. 1-1-19; 101-81, eff. 7-12-19; 101-84, eff. 7-19-19.)

Section 90-35. The Illinois Public Aid Code is amended by changing Sections 5-2, 5-4.2, 5-5e, 5-16.8, 5B-4, and 11-5.1 and by adding Sections 5-1.5, 5-5.27 and 12-21.21 as follows:

(305 ILCS 5/5-1.5 new)

Sec. 5-1.5. COVID-19 public health emergency. Notwithstanding any other provision of Articles V, XI, and XII of this Code, the Department may take necessary actions to address the COVID-19 public health emergency to the extent such actions are required, approved, or authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Such actions may continue throughout the public health emergency and for up to 12 months after the period ends, and may include, but are not limited to:

accepting an applicant's or recipient's attestation of income, incurred medical expenses, residency, and insured status when electronic verification is not available; eliminating resource tests for some eligibility determinations; suspending redeterminations; suspending changes that would adversely affect an applicant's or recipient's eligibility; phone or verbal approval by an applicant to submit an application in lieu of applicant signature; allowing adult presumptive eligibility; allowing presumptive eligibility for children, pregnant women, and adults as often as twice per calendar year; paying for additional services delivered by telehealth; and suspending premium and co-payment requirements.

The Department's authority under this Section shall only extend to encompass, incorporate, or effectuate the terms, items, conditions, and other provisions approved, authorized, or required by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, and shall not extend beyond the time of the COVID-19 public health emergency and up to 12 months after the period expires.

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

Sec. 5-2. Classes of Persons Eligible.

Medical assistance under this Article shall be available to any of the following classes of persons in respect to whom a plan for coverage has been submitted to the Governor by the Illinois Department and approved by him. If changes made in

this Section 5-2 require federal approval, they shall not take effect until such approval has been received:

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

2. Beginning January 1, 2014, persons otherwise eligible for basic maintenance under Article III, excluding any eligibility requirements that are inconsistent with any federal law or federal regulation, as interpreted by the U.S. Department of Health and Human Services, but who fail to qualify thereunder on the basis of need, and who have insufficient income and resources to meet the costs of necessary medical care, including but not limited to the following:

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

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

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

(b) (Blank).

3. (Blank).

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

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

(b) The plan for coverage shall provide ambulatory prenatal care to pregnant women during a presumptive eligibility period and establish an income eligibility standard that is equal to 200% of the federal poverty level, provided that costs incurred for medical care are

not taken into account in determining such income eligibility.

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

6. (a) Children younger than age 19 when countable income is at or below 133% of the federal poverty level. Until September 30, 2019, or sooner if the maintenance of effort requirements under the Patient Protection and Affordable Care Act are eliminated or may be waived before then, children younger than age 19 whose countable monthly income, after the deduction of costs incurred for medical care and for other types of remedial care as specified in administrative rule, is equal to or less than the Medical Assistance-No Grant(C) (MANG(C)) Income Standard in effect on April 1, 2013 as set forth in administrative rule.

(b) Children and youth who are under temporary custody

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

7. (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Medical assistance" under this paragraph 12 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. The Department must request federal approval of the coverage under this paragraph 12 within 30 days after the effective date of this amendatory Act of the 92nd General Assembly.

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

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

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

14. Subject to the availability of funds for this purpose, the Department may provide coverage under this Article to persons who reside in Illinois who are not eligible under any of the preceding paragraphs and who meet the income guidelines of paragraph 2(a) of this Section and (i) have an application for asylum pending before the federal Department of Homeland Security or on appeal before a court of competent jurisdiction and are represented either by counsel or by an advocate accredited by the federal Department of Homeland Security and employed by a not-for-profit organization in regard to that application or appeal, or (ii) are receiving services through a federally funded torture treatment center. Medical coverage under this paragraph 14 may be provided for up to 24 continuous months from the initial eligibility date so

long as an individual continues to satisfy the criteria of this paragraph 14. If an individual has an appeal pending regarding an application for asylum before the Department of Homeland Security, eligibility under this paragraph 14 may be extended until a final decision is rendered on the appeal. The Department may adopt rules governing the implementation of this paragraph 14.

15. Family Care Eligibility.

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

(b) Eligibility shall be reviewed annually.

(c) (Blank).

(d) (Blank).

(e) (Blank).

(f) (Blank).

(g) (Blank).

(h) (Blank).

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

16. Subject to appropriation, uninsured persons who are not otherwise eligible under this Section who have been

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

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

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

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

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

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

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

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

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

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

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

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

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

statutory authority.

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

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

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

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

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

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

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

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

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

(Source: P.A. 101-10, eff. 6-5-19.)

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

Sec. 5-4.2. Ambulance services payments.

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

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

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

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

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

(c-2) For purposes of this Section, "ground ambulance service provider" means a vehicle service provider as described in the Emergency Medical Services (EMS) Systems Act that operates licensed ambulances for the purpose of providing emergency ambulance services, or non-emergency ambulance services, or both. For purposes of this Section, this includes both ambulance providers and ambulance suppliers as described by the Centers for Medicare and Medicaid Services.

(c-3) For purposes of this Section, "medi-car" means transportation services provided to a patient who is confined to a wheelchair and requires the use of a hydraulic or electric lift or ramp and wheelchair lockdown when the patient's condition does not require medical observation, medical supervision, medical equipment, the administration of medications, or the administration of oxygen.

(c-4) For purposes of this Section, "service car" means transportation services provided to a patient by a passenger vehicle where that patient does not require the specialized modes described in subsection (c-1) or (c-3).

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

(e) Beginning with services rendered on or after July 1, 2008, all providers of non-emergency medi-car and service car transportation must certify that the driver and employee attendant, as applicable, have completed a safety program

approved by the Department to protect both the patient and the driver, prior to transporting a patient. The provider must maintain this certification in its records. The provider shall produce such documentation upon demand by the Department or its representative. Failure to produce documentation of such training shall result in recovery of any payments made by the Department for services rendered by a non-certified driver or employee attendant. Medi-car and service car providers must maintain legible documentation in their records of the driver and, as applicable, employee attendant that actually transported the patient. Providers must recertify all drivers and employee attendants every 3 years.

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

(f) With respect to any policy or program administered by the Department or its agent regarding approval of non-emergency medical transportation by ground ambulance service providers, including, but not limited to, the Non-Emergency Transportation Services Prior Approval Program (NETSPAP), the Department shall establish by rule a process by which ground ambulance service providers of non-emergency medical transportation may appeal any decision by the Department or its

agent for which no denial was received prior to the time of transport that either (i) denies a request for approval for payment of non-emergency transportation by means of ground ambulance service or (ii) grants a request for approval of non-emergency transportation by means of ground ambulance service at a level of service that entitles the ground ambulance service provider to a lower level of compensation from the Department than the ground ambulance service provider would have received as compensation for the level of service requested. The rule shall be filed by December 15, 2012 and shall provide that, for any decision rendered by the Department or its agent on or after the date the rule takes effect, the ground ambulance service provider shall have 60 days from the date the decision is received to file an appeal. The rule established by the Department shall be, insofar as is practical, consistent with the Illinois Administrative Procedure Act. The Director's decision on an appeal under this Section shall be a final administrative decision subject to review under the Administrative Review Law.

(f-5) Beginning 90 days after July 20, 2012 (the effective date of Public Act 97-842), (i) no denial of a request for approval for payment of non-emergency transportation by means of ground ambulance service, and (ii) no approval of non-emergency transportation by means of ground ambulance service at a level of service that entitles the ground ambulance service provider to a lower level of compensation

from the Department than would have been received at the level of service submitted by the ground ambulance service provider, may be issued by the Department or its agent unless the Department has submitted the criteria for determining the appropriateness of the transport for first notice publication in the Illinois Register pursuant to Section 5-40 of the Illinois Administrative Procedure Act.

(g) Whenever a patient covered by a medical assistance program under this Code or by another medical program administered by the Department, including a patient covered under the State's Medicaid managed care program, is being transported from a facility and requires non-emergency transportation including ground ambulance, medi-car, or service car transportation, a Physician Certification Statement as described in this Section shall be required for each patient. Facilities shall develop procedures for a licensed medical professional to provide a written and signed Physician Certification Statement. The Physician Certification Statement shall specify the level of transportation services needed and complete a medical certification establishing the criteria for approval of non-emergency ambulance transportation, as published by the Department of Healthcare and Family Services, that is met by the patient. This certification shall be completed prior to ordering the transportation service and prior to patient discharge. The Physician Certification Statement is not required prior to

transport if a delay in transport can be expected to negatively affect the patient outcome. If the ground ambulance provider, medi-car provider, or service car provider is unable to obtain the required Physician Certification Statement within 10 calendar days following the date of the service, the ground ambulance provider, medi-car provider, or service car provider must document its attempt to obtain the requested certification and may then submit the claim for payment. Acceptable documentation includes a signed return receipt from the U.S. Postal Service, facsimile receipt, email receipt, or other similar service that evidences that the ground ambulance provider, medi-car provider, or service car provider attempted to obtain the required Physician Certification Statement.

The medical certification specifying the level and type of non-emergency transportation needed shall be in the form of the Physician Certification Statement on a standardized form prescribed by the Department of Healthcare and Family Services. Within 75 days after July 27, 2018 (the effective date of Public Act 100-646), the Department of Healthcare and Family Services shall develop a standardized form of the Physician Certification Statement specifying the level and type of transportation services needed in consultation with the Department of Public Health, Medicaid managed care organizations, a statewide association representing ambulance providers, a statewide association representing hospitals, 3 statewide associations representing nursing homes, and other

stakeholders. The Physician Certification Statement shall include, but is not limited to, the criteria necessary to demonstrate medical necessity for the level of transport needed as required by (i) the Department of Healthcare and Family Services and (ii) the federal Centers for Medicare and Medicaid Services as outlined in the Centers for Medicare and Medicaid Services' Medicare Benefit Policy Manual, Pub. 100-02, Chap. 10, Sec. 10.2.1, et seq. The use of the Physician Certification Statement shall satisfy the obligations of hospitals under Section 6.22 of the Hospital Licensing Act and nursing homes under Section 2-217 of the Nursing Home Care Act. Implementation and acceptance of the Physician Certification Statement shall take place no later than 90 days after the issuance of the Physician Certification Statement by the Department of Healthcare and Family Services.

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

Beginning October 1, 2018, the Department of Healthcare and Family Services shall collect data from Medicaid managed care organizations and transportation brokers, including the Department's NETSPAP broker, regarding denials and appeals

related to the missing or incomplete Physician Certification Statement forms and overall compliance with this subsection. The Department of Healthcare and Family Services shall publish quarterly results on its website within 15 days following the end of each quarter.

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

(i) On and after July 1, 2018, the Department shall increase the base rate of reimbursement for both base charges and mileage charges for ground ambulance service providers for medical transportation services provided by means of a ground ambulance to a level not lower than 112% of the base rate in effect as of June 30, 2018.

(Source: P.A. 100-587, eff. 6-4-18; 100-646, eff. 7-27-18; 101-81, eff. 7-12-19.)

(305 ILCS 5/5-5.27 new)

Sec. 5-5.27. Coverage for clinical trials.

(a) The medical assistance program shall provide coverage for routine care costs that are incurred in the course of an approved clinical trial if the medical assistance program would provide coverage for the same routine care costs not incurred in a clinical trial. "Routine care cost" shall be defined by

the Department by rule.

(b) The coverage that must be provided under this Section is subject to the terms, conditions, restrictions, exclusions, and limitations that apply generally under the medical assistance program, including terms, conditions, restrictions, exclusions, or limitations that apply to health care services rendered by participating providers and nonparticipating providers.

(c) Implementation of this Section shall be contingent upon federal approval. Upon receipt of federal approval, if required, the Department shall adopt any rules necessary to implement this Section.

(d) As used in this Section:

"Approved clinical trial" means a phase I, II, III, or IV clinical trial involving the prevention, detection, or treatment of cancer or any other life-threatening disease or condition if one or more of the following conditions apply:

(1) the Department makes a determination that the study or investigation is an approved clinical trial;

(2) the study or investigation is conducted under an investigational new drug application or an investigational device exemption reviewed by the federal Food and Drug Administration;

(3) the study or investigation is a drug trial that is exempt from having an investigational new drug application or an investigational device exemption from the federal

Food and Drug Administration; or

(4) the study or investigation is approved or funded (which may include funding through in-kind contributions) by:

(A) the National Institutes of Health;

(B) the Centers for Disease Control and Prevention;

(C) the Agency for Healthcare Research and Quality;

(D) the Patient-Centered Outcomes Research Institute;

(E) the federal Centers for Medicare and Medicaid Services;

(F) a cooperative group or center of any of the entities described in subparagraphs (A) through (E) or the United States Department of Defense or the United States Department of Veterans Affairs;

(G) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(H) the United States Department of Veterans Affairs, the United States Department of Defense, or the United States Department of Energy, provided that review and approval of the study or investigation occurs through a system of peer review that is comparable to the peer review of studies performed by

the National Institutes of Health, including an unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

"Care method" means the use of a particular drug or device in a particular manner.

"Life-threatening disease or condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(305 ILCS 5/5-5e)

Sec. 5-5e. Adjusted rates of reimbursement.

(a) Rates or payments for services in effect on June 30, 2012 shall be adjusted and services shall be affected as required by any other provision of Public Act 97-689. In addition, the Department shall do the following:

(1) Delink the per diem rate paid for supportive living facility services from the per diem rate paid for nursing facility services, effective for services provided on or after May 1, 2011 and before July 1, 2019.

(2) Cease payment for bed reserves in nursing facilities and specialized mental health rehabilitation facilities; for purposes of therapeutic home visits for individuals scoring as TBI on the MDS 3.0, beginning June 1, 2015, the Department shall approve payments for bed reserves in nursing facilities and specialized mental

health rehabilitation facilities that have at least a 90% occupancy level and at least 80% of their residents are Medicaid eligible. Payment shall be at a daily rate of 75% of an individual's current Medicaid per diem and shall not exceed 10 days in a calendar month.

(2.5) Cease payment for bed reserves for purposes of inpatient hospitalizations to intermediate care facilities for persons with developmental ~~development~~ disabilities, except in the instance of residents who are under 21 years of age.

(3) Cease payment of the $10 per day add-on payment to nursing facilities for certain residents with developmental disabilities.

(b) After the application of subsection (a), notwithstanding any other provision of this Code to the contrary and to the extent permitted by federal law, on and after July 1, 2012, the rates of reimbursement for services and other payments provided under this Code shall further be reduced as follows:

(1) Rates or payments for physician services, dental services, or community health center services reimbursed through an encounter rate, and services provided under the Medicaid Rehabilitation Option of the Illinois Title XIX State Plan shall not be further reduced, except as provided in Section 5-5b.1.

(2) Rates or payments, or the portion thereof, paid to

a provider that is operated by a unit of local government or State University that provides the non-federal share of such services shall not be further reduced, except as provided in Section 5-5b.1.

(3) Rates or payments for hospital services delivered by a hospital defined as a Safety-Net Hospital under Section 5-5e.1 of this Code shall not be further reduced, except as provided in Section 5-5b.1.

(4) Rates or payments for hospital services delivered by a Critical Access Hospital, which is an Illinois hospital designated as a critical care hospital by the Department of Public Health in accordance with 42 CFR 485, Subpart F, shall not be further reduced, except as provided in Section 5-5b.1.

(5) Rates or payments for Nursing Facility Services shall only be further adjusted pursuant to Section 5-5.2 of this Code.

(6) Rates or payments for services delivered by long term care facilities licensed under the ID/DD Community Care Act or the MC/DD Act and developmental training services shall not be further reduced.

(7) Rates or payments for services provided under capitation rates shall be adjusted taking into consideration the rates reduction and covered services required by Public Act 97-689.

(8) For hospitals not previously described in this

subsection, the rates or payments for hospital services shall be further reduced by 3.5%, except for payments authorized under Section 5A-12.4 of this Code.

(9) For all other rates or payments for services delivered by providers not specifically referenced in paragraphs (1) through (8), rates or payments shall be further reduced by 2.7%.

(c) Any assessment imposed by this Code shall continue and nothing in this Section shall be construed to cause it to cease.

(d) Notwithstanding any other provision of this Code to the contrary, subject to federal approval under Title XIX of the Social Security Act, for dates of service on and after July 1, 2014, rates or payments for services provided for the purpose of transitioning children from a hospital to home placement or other appropriate setting by a children's community-based health care center authorized under the Alternative Health Care Delivery Act shall be $683 per day.

(e) (Blank) ~~Notwithstanding any other provision of this Code to the contrary, subject to federal approval under Title XIX of the Social Security Act, for dates of service on and after July 1, 2014, rates or payments for home health visits shall be $72~~.

(f) (Blank) ~~Notwithstanding any other provision of this Code to the contrary, subject to federal approval under Title XIX of the Social Security Act, for dates of service on and~~

~~after July 1, 2014, rates or payments for the certified nursing assistant component of the home health agency rate shall be $20~~.

(Source: P.A. 101-10, eff. 6-5-19; revised 9-12-19.)

(305 ILCS 5/5-16.8)

Sec. 5-16.8. Required health benefits. The medical assistance program shall (i) provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.6, 356z.26, 356z.29, ~~and~~ 356z.32, ~~and~~ 356z.33, 356z.34, and 356z.35 of the Illinois Insurance Code and (ii) be subject to the provisions of Sections 356z.19, 364.01, 370c, and 370c.1 of the Illinois Insurance Code.

The Department, by rule, shall adopt a model similar to the requirements of Section 356z.39 of the Illinois Insurance Code.

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

To ensure full access to the benefits set forth in this Section, on and after January 1, 2016, the Department shall ensure that provider and hospital reimbursement for post-mastectomy care benefits required under this Section are

no lower than the Medicare reimbursement rate.

(Source: P.A. 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 101-81, eff. 7-12-19; 101-218, eff. 1-1-20; 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-574, eff. 1-1-20; revised 10-16-19.)

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

Sec. 5B-4. Payment of assessment; penalty.

(a) The assessment imposed by Section 5B-2 shall be due and payable monthly, on the last State business day of the month for occupied bed days reported for the preceding third month prior to the month in which the tax is payable and due. A facility that has delayed payment due to the State's failure to reimburse for services rendered may request an extension on the due date for payment pursuant to subsection (b) and shall pay the assessment within 30 days of reimbursement by the Department. The Illinois Department may provide that county nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their assessment obligation by certifying to the Illinois Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the assessment.

(a-5) The Illinois Department shall provide for an electronic submission process for each long-term care facility to report at a minimum the number of occupied bed days of the

long-term care facility for the reporting period and other reasonable information the Illinois Department requires for the administration of its responsibilities under this Code. Beginning July 1, 2013, a separate electronic submission shall be completed for each long-term care facility in this State operated by a long-term care provider. The Illinois Department shall provide a self-reporting notice of the assessment form that the long-term care facility completes for the required period and submits with its assessment payment to the Illinois Department. ~~shall prepare an assessment bill stating the amount due and payable each month and submit it to each long-term care facility via an electronic process. Each assessment payment shall be accompanied by a copy of the assessment bill sent to the long term care facility by the Illinois Department.~~ To the extent practicable, the Department shall coordinate the assessment reporting requirements with other reporting required of long-term care facilities.

(b) The Illinois Department is authorized to establish delayed payment schedules for long-term care providers that are unable to make assessment payments when due under this Section due to financial difficulties, as determined by the Illinois Department. The Illinois Department may not deny a request for delay of payment of the assessment imposed under this Article if the long-term care provider has not been paid for services provided during the month on which the assessment is levied or the Medicaid managed care organization has not been paid by the

State.

(c) If a long-term care provider fails to pay the full amount of an assessment payment when due (including any extensions granted under subsection (b)), there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5B-2 a penalty assessment equal to the lesser of (i) 5% of the amount of the assessment payment not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter or (ii) 100% of the assessment payment amount not paid on or before the due date. For purposes of this subsection, payments will be credited first to unpaid assessment payment amounts (rather than to penalty or interest), beginning with the most delinquent assessment payments. Payment cycles of longer than 60 days shall be one factor the Director takes into account in granting a waiver under this Section.

(c-5) If a long-term care facility fails to file its assessment bill with payment, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment due a penalty assessment equal to 25% of the assessment due. After July 1, 2013, no penalty shall be assessed under this Section if the Illinois Department does not provide a process for the electronic submission of the information required by subsection (a-5).

(d) Nothing in this amendatory Act of 1993 shall be

construed to prevent the Illinois Department from collecting all amounts due under this Article pursuant to an assessment imposed before the effective date of this amendatory Act of 1993.

(e) Nothing in this amendatory Act of the 96th General Assembly shall be construed to prevent the Illinois Department from collecting all amounts due under this Code pursuant to an assessment, tax, fee, or penalty imposed before the effective date of this amendatory Act of the 96th General Assembly.

(f) No installment of the assessment imposed by Section 5B-2 shall be due and payable until after the Department notifies the long-term care providers, in writing, that the payment methodologies to long-term care providers required under Section 5-5.4 of this Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. Upon notification to the Department of approval of the payment methodologies required under Section 5-5.4 of this Code and the waivers granted under 42 CFR 433.68, all installments otherwise due under Section 5B-4 prior to the date of notification shall be due and payable to the Department upon written direction from the Department within 90 days after issuance by the Comptroller of the payments required under

Section 5-5.4 of this Code.

(Source: P.A. 100-501, eff. 6-1-18.)

(305 ILCS 5/11-5.1)

Sec. 11-5.1. Eligibility verification. Notwithstanding any other provision of this Code, with respect to applications for medical assistance provided under Article V of this Code, eligibility shall be determined in a manner that ensures program integrity and complies with federal laws and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By no later than July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants for medical assistance under this Code. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income

extrapolated from the time period covered by the pay stub.

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility for medical assistance under this Code. Information the Department receives prior to the annual review, including information available to the Department as a result of the recipient's application for other non-Medicaid benefits, that is sufficient to make a determination of continued Medicaid eligibility may be reviewed and verified, and subsequent action taken including client notification of continued Medicaid eligibility. The date of client notification establishes the date for subsequent annual Medicaid eligibility reviews. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient

does not fulfill the requirements for continued eligibility by the deadline established in the notice a notice of cancellation shall be issued to the recipient and coverage shall end no later than the last day of the month following the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By no later than July 1, 2011, require verification of Illinois residency.

The Department, with federal approval, may choose to adopt continuous financial eligibility for a full 12 months for adults on Medicaid.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the

Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data shall be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.

(d) As soon as practical if the data is reasonably available, but no later than January 1, 2017, the Department shall compile on a monthly basis data on eligibility redeterminations of beneficiaries of medical assistance provided under Article V of this Code. This data shall be posted on the Department's website, and data from prior months shall be retained and available on the Department's website. The data compiled and reported shall include the following:

(1) The total number of redetermination decisions made in a month and, of that total number, the number of decisions to continue or change benefits and the number of decisions to cancel benefits.

(2) A breakdown of enrollee language preference for the total number of redetermination decisions made in a month

and, of that total number, a breakdown of enrollee language preference for the number of decisions to continue or change benefits, and a breakdown of enrollee language preference for the number of decisions to cancel benefits. The language breakdown shall include, at a minimum, English, Spanish, and the next 4 most commonly used languages.

(3) The percentage of cancellation decisions made in a month due to each of the following:

(A) The beneficiary's ineligibility due to excess income.

(B) The beneficiary's ineligibility due to not being an Illinois resident.

(C) The beneficiary's ineligibility due to being deceased.

(D) The beneficiary's request to cancel benefits.

(E) The beneficiary's lack of response after notices mailed to the beneficiary are returned to the Department as undeliverable by the United States Postal Service.

(F) The beneficiary's lack of response to a request for additional information when reliable information in the beneficiary's account, or other more current information, is unavailable to the Department to make a decision on whether to continue benefits.

(G) Other reasons tracked by the Department for the

purpose of ensuring program integrity.

(4) If a vendor is utilized to provide services in support of the Department's redetermination decision process, the total number of redetermination decisions made in a month and, of that total number, the number of decisions to continue or change benefits, and the number of decisions to cancel benefits (i) with the involvement of the vendor and (ii) without the involvement of the vendor.

(5) Of the total number of benefit cancellations in a month, the number of beneficiaries who return from cancellation within one month, the number of beneficiaries who return from cancellation within 2 months, and the number of beneficiaries who return from cancellation within 3 months. Of the number of beneficiaries who return from cancellation within 3 months, the percentage of those cancellations due to each of the reasons listed under paragraph (3) of this subsection.

(e) The Department shall conduct a complete review of the Medicaid redetermination process in order to identify changes that can increase the use of ex parte redetermination processing. This review shall be completed within 90 days after the effective date of this amendatory Act of the 101st General Assembly. Within 90 days of completion of the review, the Department shall seek written federal approval of policy changes the review recommended and implement once approved. The review shall specifically include, but not be limited to, use

of ex parte redeterminations of the following populations:

(1) Recipients of developmental disabilities services.

(2) Recipients of benefits under the State's Aid to the Aged, Blind, or Disabled program.

(3) Recipients of Medicaid long-term care services and supports, including waiver services.

(4) All Modified Adjusted Gross Income (MAGI) populations.

(5) Populations with no verifiable income.

(6) Self-employed people.

The report shall also outline populations and circumstances in which an ex parte redetermination is not a recommended option.

(f) The Department shall explore and implement, as practical and technologically possible, roles that stakeholders outside State agencies can play to assist in expediting eligibility determinations and redeterminations within 24 months after the effective date of this amendatory Act of the 101st General Assembly. Such practical roles to be explored to expedite the eligibility determination processes shall include the implementation of hospital presumptive eligibility, as authorized by the Patient Protection and Affordable Care Act.

(g) The Department or its designee shall seek federal approval to enhance the reasonable compatibility standard from 5% to 10%.

(h) Reporting. The Department of Healthcare and Family Services and the Department of Human Services shall publish quarterly reports on their progress in implementing policies and practices pursuant to this Section as modified by this amendatory Act of the 101st General Assembly.

(1) The reports shall include, but not be limited to, the following:

(A) Medical application processing, including a breakdown of the number of MAGI, non-MAGI, long-term care, and other medical cases pending for various incremental time frames between 0 to 181 or more days.

(B) Medical redeterminations completed, including: (i) a breakdown of the number of households that were redetermined ex parte and those that were not; (ii) the reasons households were not redetermined ex parte; and (iii) the relative percentages of these reasons.

(C) A narrative discussion on issues identified in the functioning of the State's Integrated Eligibility System and progress on addressing those issues, as well as progress on implementing strategies to address eligibility backlogs, including expanding ex parte determinations to ensure timely eligibility determinations and renewals.

(2) Initial reports shall be issued within 90 days after the effective date of this amendatory Act of the 101st General Assembly.

(3) All reports shall be published on the Department's website.

(Source: P.A. 101-209, eff. 8-5-19.)

(305 ILCS 5/12-21.21 new)

Sec. 12-21.21. Federal waiver or State Plan amendment. The Department of Healthcare and Family Services and the Department of Human Services shall jointly submit the necessary application to the federal Centers for Medicare and Medicaid Services for a waiver or State Plan amendment to allow remote monitoring and support services as a waiver-reimbursable service for persons with intellectual and developmental disabilities. The application shall be submitted no later than January 1, 2021.

No later than July 1, 2021, the Department of Human Services shall adopt rules to allow remote monitoring and support services at community-integrated living arrangements.

Section 90-40. The Medical Patient Rights Act is amended by changing Section 3 as follows:

(410 ILCS 50/3) (from Ch. 111 1/2, par. 5403)

Sec. 3. The following rights are hereby established:

(a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to

receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law.

(b) The right of each patient, regardless of source of payment, to examine and receive a reasonable explanation of his total bill for services rendered by his physician or health care provider, including the itemized charges for specific services received. Each physician or health care provider shall be responsible only for a reasonable explanation of those specific services provided by such physician or health care provider.

(c) In the event an insurance company or health services corporation cancels or refuses to renew an individual policy or plan, the insured patient shall be entitled to timely, prior notice of the termination of such policy or plan.

An insurance company or health services corporation that requires any insured patient or applicant for new or continued insurance or coverage to be tested for infection with human immunodeficiency virus (HIV) or any other identified causative agent of acquired immunodeficiency syndrome (AIDS) shall (1) give the patient or applicant prior written notice of such requirement, (2) proceed with such testing only upon the written authorization of the applicant or patient, and (3) keep the results of such testing confidential. Notice of an adverse underwriting or coverage decision may be given to any

appropriately interested party, but the insurer may only disclose the test result itself to a physician designated by the applicant or patient, and any such disclosure shall be in a manner that assures confidentiality.

The Department of Insurance shall enforce the provisions of this subsection.

(d) The right of each patient to privacy and confidentiality in health care. Each physician, health care provider, health services corporation and insurance company shall refrain from disclosing the nature or details of services provided to patients, except that such information may be disclosed: (1) to the patient, (2) to the party making treatment decisions if the patient is incapable of making decisions regarding the health services provided, (3) for treatment in accordance with 45 CFR 164.501 and 164.506, (4) for payment in accordance with 45 CFR 164.501 and 164.506, (5) to those parties responsible for peer review, utilization review, and quality assurance, (6) for health care operations in accordance with 45 CFR 164.501 and 164.506, (7) to those parties required to be notified under the Abused and Neglected Child Reporting Act or the Illinois Sexually Transmissible Disease Control Act, or (8) as otherwise permitted, authorized, or required by State or federal law. This right may be waived in writing by the patient or the patient's guardian or legal representative, but a physician or other health care provider may not condition the provision of services on the patient's,

guardian's, or legal representative's agreement to sign such a waiver. In the interest of public health, safety, and welfare, patient information, including, but not limited to, health information, demographic information, and information about the services provided to patients, may be transmitted to or through a health information exchange, as that term is defined in Section 2 of the Mental Health and Developmental Disabilities Confidentiality Act, in accordance with the disclosures permitted pursuant to this Section. Patients shall be provided the opportunity to opt out of their health information being transmitted to or through a health information exchange in accordance with the regulations, standards, or contractual obligations adopted by the Illinois Health Information Exchange Office ~~Authority~~ in accordance with Section 9.6 of the Mental Health and Developmental Disabilities Confidentiality Act, Section 9.6 of the AIDS Confidentiality Act, or Section 31.8 of the Genetic Information Privacy Act, as applicable. In the case of a patient choosing to opt out of having his or her information available on an HIE, nothing in this Act shall cause the physician or health care provider to be liable for the release of a patient's health information by other entities that may possess such information, including, but not limited to, other health professionals, providers, laboratories, pharmacies, hospitals, ambulatory surgical centers, and nursing homes.

(Source: P.A. 98-1046, eff. 1-1-15.)

Section 90-45. The Genetic Information Privacy Act is amended by changing Section 10 as follows:

(410 ILCS 513/10)

Sec. 10. Definitions. As used in this Act:

"Office ~~Authority~~" means the Illinois Health Information Exchange Office ~~Authority~~ established pursuant to the Illinois Health Information Exchange and Technology Act.

"Business associate" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 160.103.

"Covered entity" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 160.103.

"De-identified information" means health information that is not individually identifiable as described under HIPAA, as specified in 45 CFR 164.514(b).

"Disclosure" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 160.103.

"Employer" means the State of Illinois, any unit of local government, and any board, commission, department, institution, or school district, any party to a public contract, any joint apprenticeship or training committee within the State, and every other person employing employees within the State.

"Employment agency" means both public and private employment agencies and any person, labor organization, or

labor union having a hiring hall or hiring office regularly undertaking, with or without compensation, to procure opportunities to work, or to procure, recruit, refer, or place employees.

"Family member" means, with respect to an individual, (i) the spouse of the individual; (ii) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; (iii) any other person qualifying as a covered dependent under a managed care plan; and (iv) all other individuals related by blood or law to the individual or the spouse or child described in subsections (i) through (iii) of this definition.

"Genetic information" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 160.103.

"Genetic monitoring" means the periodic examination of employees to evaluate acquired modifications to their genetic material, such as chromosomal damage or evidence of increased occurrence of mutations that may have developed in the course of employment due to exposure to toxic substances in the workplace in order to identify, evaluate, and respond to effects of or control adverse environmental exposures in the workplace.

"Genetic services" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 160.103.

"Genetic testing" and "genetic test" have the meaning ascribed to "genetic test" under HIPAA, as specified in 45 CFR

160.103. "Genetic testing" includes direct-to-consumer commercial genetic testing.

"Health care operations" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 164.501.

"Health care professional" means (i) a licensed physician, (ii) a licensed physician assistant, (iii) a licensed advanced practice registered nurse, (iv) a licensed dentist, (v) a licensed podiatrist, (vi) a licensed genetic counselor, or (vii) an individual certified to provide genetic testing by a state or local public health department.

"Health care provider" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 160.103.

"Health facility" means a hospital, blood bank, blood center, sperm bank, or other health care institution, including any "health facility" as that term is defined in the Illinois Finance Authority Act.

"Health information exchange" or "HIE" means a health information exchange or health information organization that exchanges health information electronically that (i) is established pursuant to the Illinois Health Information Exchange and Technology Act, or any subsequent amendments thereto, and any administrative rules promulgated thereunder; (ii) has established a data sharing arrangement with the Office ~~Authority~~; or (iii) as of August 16, 2013, was designated by the Illinois Health Information Exchange Authority (now Office) Board as a member of, or was represented on, the

Authority Board's Regional Health Information Exchange Workgroup; provided that such designation shall not require the establishment of a data sharing arrangement or other participation with the Illinois Health Information Exchange or the payment of any fee. In certain circumstances, in accordance with HIPAA, an HIE will be a business associate.

"Health oversight agency" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 164.501.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, Public Law 111-05, and any subsequent amendments thereto and any regulations promulgated thereunder.

"Insurer" means (i) an entity that is subject to the jurisdiction of the Director of Insurance and (ii) a managed care plan.

"Labor organization" includes any organization, labor union, craft union, or any voluntary unincorporated association designed to further the cause of the rights of union labor that is constituted for the purpose, in whole or in part, of collective bargaining or of dealing with employers concerning grievances, terms or conditions of employment, or apprenticeships or applications for apprenticeships, or of other mutual aid or protection in connection with employment, including apprenticeships or applications for apprenticeships.

"Licensing agency" means a board, commission, committee,

council, department, or officers, except a judicial officer, in this State or any political subdivision authorized to grant, deny, renew, revoke, suspend, annul, withdraw, or amend a license or certificate of registration.

"Limited data set" has the meaning ascribed to it under HIPAA, as described in 45 CFR 164.514(e)(2).

"Managed care plan" means a plan that establishes, operates, or maintains a network of health care providers that have entered into agreements with the plan to provide health care services to enrollees where the plan has the ultimate and direct contractual obligation to the enrollee to arrange for the provision of or pay for services through:

(1) organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution; or

(2) financial incentives for persons enrolled in the plan to use the participating providers and procedures covered by the plan.

A managed care plan may be established or operated by any entity including a licensed insurance company, hospital or medical service plan, health maintenance organization, limited health service organization, preferred provider organization, third party administrator, or an employer or employee organization.

"Minimum necessary" means HIPAA's standard for using, disclosing, and requesting protected health information found

in 45 CFR 164.502(b) and 164.514(d).

"Nontherapeutic purpose" means a purpose that is not intended to improve or preserve the life or health of the individual whom the information concerns.

"Organized health care arrangement" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 160.103.

"Patient safety activities" has the meaning ascribed to it under 42 CFR 3.20.

"Payment" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 164.501.

"Person" includes any natural person, partnership, association, joint venture, trust, governmental entity, public or private corporation, health facility, or other legal entity.

"Protected health information" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 164.103.

"Research" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 164.501.

"State agency" means an instrumentality of the State of Illinois and any instrumentality of another state which pursuant to applicable law or a written undertaking with an instrumentality of the State of Illinois is bound to protect the privacy of genetic information of Illinois persons.

"Treatment" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 164.501.

"Use" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 160.103, where context dictates.

(Source: P.A. 100-513, eff. 1-1-18; 101-132, eff. 1-1-20.)

Section 90-50. The Mental Health and Developmental Disabilities Confidentiality Act is amended by changing Sections 2, 9.5, 9.6, 9.8, 9.9, and 9.11 as follows:

(740 ILCS 110/2) (from Ch. 91 1/2, par. 802)

Sec. 2. The terms used in this Act, unless the context requires otherwise, have the meanings ascribed to them in this Section.

"Agent" means a person who has been legally appointed as an individual's agent under a power of attorney for health care or for property.

"Business associate" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 160.103.

"Confidential communication" or "communication" means any communication made by a recipient or other person to a therapist or to or in the presence of other persons during or in connection with providing mental health or developmental disability services to a recipient. Communication includes information which indicates that a person is a recipient. "Communication" does not include information that has been de-identified in accordance with HIPAA, as specified in 45 CFR 164.514.

"Covered entity" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 160.103.

"Guardian" means a legally appointed guardian or conservator of the person.

"Health information exchange" or "HIE" means a health information exchange or health information organization that oversees and governs the electronic exchange of health information that (i) is established pursuant to the Illinois Health Information Exchange and Technology Act, or any subsequent amendments thereto, and any administrative rules promulgated thereunder; or (ii) has established a data sharing arrangement with the Illinois Health Information Exchange; or (iii) as of the effective date of this amendatory Act of the 98th General Assembly, was designated by the Illinois Health Information Exchange Office ~~Authority~~ Board as a member of, or was represented on, the Office ~~Authority~~ Board's Regional Health Information Exchange Workgroup; provided that such designation shall not require the establishment of a data sharing arrangement or other participation with the Illinois Health Information Exchange or the payment of any fee.

"HIE purposes" means those uses and disclosures (as those terms are defined under HIPAA, as specified in 45 CFR 160.103) for activities of an HIE: (i) set forth in the Illinois Health Information Exchange and Technology Act or any subsequent amendments thereto and any administrative rules promulgated thereunder; or (ii) which are permitted under federal law.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any

subsequent amendments thereto and any regulations promulgated thereunder, including the Security Rule, as specified in 45 CFR 164.302-18, and the Privacy Rule, as specified in 45 CFR 164.500-34.

"Integrated health system" means an organization with a system of care which incorporates physical and behavioral healthcare and includes care delivered in an inpatient and outpatient setting.

"Interdisciplinary team" means a group of persons representing different clinical disciplines, such as medicine, nursing, social work, and psychology, providing and coordinating the care and treatment for a recipient of mental health or developmental disability services. The group may be composed of individuals employed by one provider or multiple providers.

"Mental health or developmental disabilities services" or "services" includes but is not limited to examination, diagnosis, evaluation, treatment, training, pharmaceuticals, aftercare, habilitation or rehabilitation.

"Personal notes" means:

(i) information disclosed to the therapist in confidence by other persons on condition that such information would never be disclosed to the recipient or other persons;

(ii) information disclosed to the therapist by the recipient which would be injurious to the recipient's

relationships to other persons, and

(iii) the therapist's speculations, impressions, hunches, and reminders.

"Parent" means a parent or, in the absence of a parent or guardian, a person in loco parentis.

"Recipient" means a person who is receiving or has received mental health or developmental disabilities services.

"Record" means any record kept by a therapist or by an agency in the course of providing mental health or developmental disabilities service to a recipient concerning the recipient and the services provided. "Records" includes all records maintained by a court that have been created in connection with, in preparation for, or as a result of the filing of any petition or certificate under Chapter II, Chapter III, or Chapter IV of the Mental Health and Developmental Disabilities Code and includes the petitions, certificates, dispositional reports, treatment plans, and reports of diagnostic evaluations and of hearings under Article VIII of Chapter III or under Article V of Chapter IV of that Code. Record does not include the therapist's personal notes, if such notes are kept in the therapist's sole possession for his own personal use and are not disclosed to any other person, except the therapist's supervisor, consulting therapist or attorney. If at any time such notes are disclosed, they shall be considered part of the recipient's record for purposes of this Act. "Record" does not include information that has been

de-identified in accordance with HIPAA, as specified in 45 CFR 164.514. "Record" does not include a reference to the receipt of mental health or developmental disabilities services noted during a patient history and physical or other summary of care.

"Record custodian" means a person responsible for maintaining a recipient's record.

"Therapist" means a psychiatrist, physician, psychologist, social worker, or nurse providing mental health or developmental disabilities services or any other person not prohibited by law from providing such services or from holding himself out as a therapist if the recipient reasonably believes that such person is permitted to do so. Therapist includes any successor of the therapist.

"Therapeutic relationship" means the receipt by a recipient of mental health or developmental disabilities services from a therapist. "Therapeutic relationship" does not include independent evaluations for a purpose other than the provision of mental health or developmental disabilities services.

(Source: P.A. 98-378, eff. 8-16-13; 99-28, eff. 1-1-16.)

(740 ILCS 110/9.5)

Sec. 9.5. Use and disclosure of information to an HIE.

(a) An HIE, person, therapist, facility, agency, interdisciplinary team, integrated health system, business associate, or covered entity may, without a recipient's

consent, use or disclose information from a recipient's record in connection with an HIE, including disclosure to the Illinois Health Information Exchange Office ~~Authority~~, an HIE, or the business associate of either. An HIE and its business associate may, without a recipient's consent, use or disclose and re-disclose such information for HIE purposes or for such other purposes as are specifically allowed under this Act.

(b) As used in this Section:

(1) "facility" means a developmental disability facility as defined in Section 1-107 of the Mental Health and Developmental Disabilities Code or a mental health facility as defined in Section 1-114 of the Mental Health and Developmental Disabilities Code; and

(2) the terms "disclosure" and "use" have the meanings ascribed to them under HIPAA, as specified in 45 CFR 160.103.

(Source: P.A. 98-378, eff. 8-16-13.)

(740 ILCS 110/9.6)

Sec. 9.6. HIE opt-out. The Illinois Health Information Exchange Office ~~Authority~~ shall, through appropriate rules, standards, or contractual obligations, which shall be binding upon any HIE, as defined under Section 2, require that participants of such HIE provide each recipient whose record is accessible through the health information exchange the reasonable opportunity to expressly decline the further

disclosure of the record by the health information exchange to third parties, except to the extent permitted by law such as for purposes of public health reporting. These rules, standards, or contractual obligations shall permit a recipient to revoke a prior decision to opt-out or a decision not to opt-out. These rules, standards, or contractual obligations shall provide for written notice of a recipient's right to opt-out which directs the recipient to a health information exchange website containing (i) an explanation of the purposes of the health information exchange; and (ii) audio, visual, and written instructions on how to opt-out of participation in whole or in part to the extent possible. These rules, standards, or contractual obligations shall be reviewed annually and updated as the technical options develop. The recipient shall be provided meaningful disclosure regarding the health information exchange, and the recipient's decision whether to opt-out should be obtained without undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion. To the extent that HIPAA, as specified in 45 CFR 164.508(b)(4), prohibits a covered entity from conditioning the provision of its services upon an individual's provision of an authorization, an HIE participant shall not condition the provision of its services upon a recipient's decision to opt-out of further disclosure of the record by an HIE to third parties. The Illinois Health Information Exchange Office ~~Authority~~ shall, through

appropriate rules, standards, or contractual obligations, which shall be binding upon any HIE, as defined under Section 2, give consideration to the format and content of the meaningful disclosure and the availability to recipients of information regarding an HIE and the rights of recipients under this Section to expressly decline the further disclosure of the record by an HIE to third parties. The Illinois Health Information Exchange Office ~~Authority~~ shall also give annual consideration to enable a recipient to expressly decline the further disclosure by an HIE to third parties of selected portions of the recipient's record while permitting disclosure of the recipient's remaining patient health information. In establishing rules, standards, or contractual obligations binding upon HIEs under this Section to give effect to recipient disclosure preferences, the Illinois Health Information Exchange Office ~~Authority~~ in its discretion may consider the extent to which relevant health information technologies reasonably available to therapists and HIEs in this State reasonably enable the effective segmentation of specific information within a recipient's electronic medical record and reasonably enable the effective exclusion of specific information from disclosure by an HIE to third parties, as well as the availability of sufficient authoritative clinical guidance to enable the practical application of such technologies to effect recipient disclosure preferences. The provisions of this Section 9.6

shall not apply to the secure electronic transmission of data which is point-to-point communication directed by the data custodian. Any rules or standards promulgated under this Section which apply to HIEs shall be limited to that subject matter required by this Section and shall not include any requirement that an HIE enter a data sharing arrangement or otherwise participate with the Illinois Health Information Exchange. In connection with its annual consideration regarding the issue of segmentation of information within a medical record and prior to the adoption of any rules or standards regarding that issue, the Office ~~Authority~~ Board shall consider information provided by affected persons or organizations regarding the feasibility, availability, cost, reliability, and interoperability of any technology or process under consideration by the Board. Nothing in this Act shall be construed to limit the authority of the Illinois Health Information Exchange Office ~~Authority~~ to impose limits or conditions on consent for disclosures to or through any HIE, as defined under Section 2, which are more restrictive than the requirements under this Act or under HIPAA.

(Source: P.A. 98-378, eff. 8-16-13.)

(740 ILCS 110/9.8)

Sec. 9.8. Business associates. An HIE, person, therapist, facility, agency, interdisciplinary team, integrated health system, business associate, covered entity, the Illinois

Health Information Exchange Office ~~Authority~~, or entity facilitating the establishment or operation of an HIE may, without a recipient's consent, utilize the services of and disclose information from a recipient's record to a business associate, as defined by and in accordance with the requirements set forth under HIPAA. As used in this Section, the term "disclosure" has the meaning ascribed to it by HIPAA, as specified in 45 CFR 160.103.

(Source: P.A. 98-378, eff. 8-16-13.)

(740 ILCS 110/9.9)

Sec. 9.9. Record locator service.

(a) An HIE, person, therapist, facility, agency, interdisciplinary team, integrated health system, business associate, covered entity, the Illinois Health Information Exchange Office ~~Authority~~, or entity facilitating the establishment or operation of an HIE may, without a recipient's consent, disclose the existence of a recipient's record to a record locator service, master patient index, or other directory or services necessary to support and enable the establishment and operation of an HIE.

(b) As used in this Section:

(1) the term "disclosure" has the meaning ascribed to it under HIPAA, as specified in 45 CFR 160.103; and

(2) "facility" means a developmental disability facility as defined in Section 1-107 of the Mental Health

and Developmental Disabilities Code or a mental health facility as defined in Section 1-114 of the Mental Health and Developmental Disabilities Code.

(Source: P.A. 98-378, eff. 8-16-13.)

(740 ILCS 110/9.11)

Sec. 9.11. Establishment and disclosure of limited data sets and de-identified information.

(a) An HIE, person, therapist, facility, agency, interdisciplinary team, integrated health system, business associate, covered entity, the Illinois Health Information Exchange Office ~~Authority~~, or entity facilitating the establishment or operation of an HIE may, without a recipient's consent, use information from a recipient's record to establish, or disclose such information to a business associate to establish, and further disclose information from a recipient's record as part of a limited data set as defined by and in accordance with the requirements set forth under HIPAA, as specified in 45 CFR 164.514(e). An HIE, person, therapist, facility, agency, interdisciplinary team, integrated health system, business associate, covered entity, the Illinois Health Information Exchange Office ~~Authority~~, or entity facilitating the establishment or operation of an HIE may, without a recipient's consent, use information from a recipient's record or disclose information from a recipient's record to a business associate to de-identity the information

in accordance with HIPAA, as specified in 45 CFR 164.514.

(b) As used in this Section:

(1) the terms "disclosure" and "use" shall have the meanings ascribed to them by HIPAA, as specified in 45 CFR 160.103; and

(2) "facility" means a developmental disability facility as defined in Section 1-107 of the Mental Health and Developmental Disabilities Code or a mental health facility as defined in Section 1-114 of the Mental Health and Developmental Disabilities Code.

(Source: P.A. 98-378, eff. 8-16-13.)

Article 99. Effective Date

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