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1 AMENDMENT TO SENATE BILL 1298

2 AMENDMENT NO. _____. Amend Senate Bill 1298 by replacing
3 everything after the enacting clause with the following:

4 "ARTICLE 1.

5 Section 1-1. Short title. This Article may be cited as the
6 Substance Use Disorder Residential and Detox Rate Equity Act.
7 References in this Article to "this Act" mean this Article.

8 Section 1-5. Funding for licensed or certified
9 community-based substance use disorder treatment providers.
10 Subject to federal approval, beginning on January 1, 2024 for
11 State Fiscal Year 2024, and for each State fiscal year
12 thereafter, the General Assembly shall appropriate sufficient
13 funds to the Department of Human Services to ensure
14 reimbursement rates will be increased and subsequently
15 adjusted upward by an amount equal to the Consumer Price

1 Index-U from the previous year, not to exceed 5% in any State
2 fiscal year, for licensed or certified substance use disorder
3 treatment providers of ASAM Level 3 residential/inpatient
4 services under community service grant programs for persons
5 with substance use disorders.

6 If there is a decrease in the Consumer Price Index-U,
7 rates shall remain unchanged for that State fiscal year. The
8 Department of Human Services shall increase the grant contract
9 amount awarded to each eligible community-based substance use
10 disorder treatment provider to ensure that the level and
11 number of services provided under community service grant
12 programs shall not be reduced by increasing the amount
13 available to each provider under the community service grant
14 programs to address the increased rate for each such service.

15 The Department shall adopt rules, including emergency
16 rules in accordance with Section 5-45 of the Illinois
17 Administrative Procedure Act, to implement the provisions of
18 this Act.

19 As used in this Act, "Consumer Price Index-U" means the
20 index published by the Bureau of Labor Statistics of the
21 United States Department of Labor that measures the average
22 change in prices of goods and services purchased by all urban
23 consumers, United States city average, all items, 1982-84 =
24 100.

1 Section 5-10. The Illinois Administrative Procedure Act is
2 amended by adding Section 5-45.35 as follows:

3 (5 ILCS 100/5-45.35 new)

4 Sec. 5-45.35. Emergency rulemaking; Substance Use Disorder
5 Residential and Detox Rate Equity. To provide for the
6 expeditious and timely implementation of the Substance Use
7 Disorder Residential and Detox Rate Equity Act, emergency
8 rules implementing the Substance Use Disorder Residential and
9 Detox Rate Equity Act may be adopted in accordance with
10 Section 5-45 by the Department of Human Services and the
11 Department of Healthcare and Family Services. The adoption of
12 emergency rules authorized by Section 5-45 and this Section is
13 deemed to be necessary for the public interest, safety, and
14 welfare.

15 This Section is repealed one year after the effective date
16 of this amendatory Act of the 103rd General Assembly.

17 Section 5-15. The Substance Use Disorder Act is amended by
18 changing Section 55-30 as follows:

19 (20 ILCS 301/55-30)

20 Sec. 55-30. Rate increase.

21 (a) The Department shall by rule develop the increased
22 rate methodology and annualize the increased rate beginning

1 with State fiscal year 2018 contracts to licensed providers of
2 community-based substance use disorder intervention or
3 treatment, based on the additional amounts appropriated for
4 the purpose of providing a rate increase to licensed
5 providers. The Department shall adopt rules, including
6 emergency rules under subsection (y) of Section 5-45 of the
7 Illinois Administrative Procedure Act, to implement the
8 provisions of this Section.

9 (b) (Blank).

10 (c) Beginning on July 1, 2022, the Division of Substance
11 Use Prevention and Recovery shall increase reimbursement rates
12 for all community-based substance use disorder treatment and
13 intervention services by 47%, including, but not limited to,
14 all of the following:

15 (1) Admission and Discharge Assessment.

16 (2) Level 1 (Individual).

17 (3) Level 1 (Group).

18 (4) Level 2 (Individual).

19 (5) Level 2 (Group).

20 (6) Case Management.

21 (7) Psychiatric Evaluation.

22 (8) Medication Assisted Recovery.

23 (9) Community Intervention.

24 (10) Early Intervention (Individual).

25 (11) Early Intervention (Group).

26 Beginning in State Fiscal Year 2023, and every State

1 fiscal year thereafter, reimbursement rates for those
2 community-based substance use disorder treatment and
3 intervention services shall be adjusted upward by an amount
4 equal to the Consumer Price Index-U from the previous year,
5 not to exceed 2% in any State fiscal year. If there is a
6 decrease in the Consumer Price Index-U, rates shall remain
7 unchanged for that State fiscal year. The Department shall
8 adopt rules, including emergency rules in accordance with the
9 Illinois Administrative Procedure Act, to implement the
10 provisions of this Section.

11 As used in this subsection, "consumer price index-u" means
12 the index published by the Bureau of Labor Statistics of the
13 United States Department of Labor that measures the average
14 change in prices of goods and services purchased by all urban
15 consumers, United States city average, all items, 1982-84 =
16 100.

17 (d) Beginning on January 1, 2024, subject to federal
18 approval, the Division of Substance Use Prevention and
19 Recovery shall increase reimbursement rates for all ASAM level
20 3 residential/inpatient substance use disorder treatment and
21 intervention services by 30%, including, but not limited to,
22 the following services:

23 (1) ASAM level 3.5 Clinically Managed High-Intensity
24 Residential Services for adults;

25 (2) ASAM level 3.5 Clinically Managed Medium-Intensity
26 Residential Services for adolescents;

1 (3) ASAM level 3.2 Clinically Managed Residential
2 Withdrawal Management;

3 (4) ASAM level 3.7 Medically Monitored Intensive
4 Inpatient Services for adults and Medically Monitored
5 High-Intensity Inpatient Services for adolescents; and

6 (5) ASAM level 3.1 Clinically Managed Low-Intensity
7 Residential Services for adults and adolescents.

8 (Source: P.A. 101-81, eff. 7-12-19; 102-699, eff. 4-19-22.)

9 Section 5-20. The Illinois Public Aid Code is amended by
10 adding Section 5-47 as follows:

11 (305 ILCS 5/5-47 new)

12 Sec. 5-47. Medicaid reimbursement rates; substance use
13 disorder treatment providers and facilities.

14 (a) Subject to federal approval, the Department of
15 Healthcare and Family Services, in conjunction with the
16 Department of Human Services' Division of Substance Use
17 Prevention and Recovery, shall provide a 30% increase in
18 reimbursement rates for all Medicaid-covered ASAM Level 3
19 residential/inpatient substance use disorder treatment
20 services.

21 No existing or future reimbursement rates or add-ons shall
22 be reduced or changed to address this proposed rate increase.
23 No later than 3 months after the effective date of this
24 amendatory Act of the 103rd General Assembly, the Department

1 of Healthcare and Family Services shall submit any necessary
2 application to the federal Centers for Medicare and Medicaid
3 Services to implement the requirements of this Section.

4 (b) Parity in community-based behavioral health rates;
5 implementation plan for cost reporting. For the purpose of
6 understanding behavioral health services cost structures and
7 their impact on the Medical Assistance Program, the Department
8 of Healthcare and Family Services shall engage stakeholders to
9 develop a plan for the regular collection of cost reporting
10 for all entity-based substance use disorder providers. Data
11 shall be used to inform on the effectiveness and efficiency of
12 Illinois Medicaid rates. The Department and stakeholders shall
13 develop a plan by April 1, 2024. The Department shall engage
14 stakeholders on implementation of the plan. The plan, at
15 minimum, shall consider all of the following:

16 (1) Alignment with certified community behavioral
17 health clinic requirements, standards, policies, and
18 procedures.

19 (2) Inclusion of prospective costs to measure what is
20 needed to increase services and capacity.

21 (3) Consideration of differences in collection and
22 policies based on the size of providers.

23 (4) Consideration of additional administrative time
24 and costs.

25 (5) Goals, purposes, and usage of data collected from
26 cost reports.

1 (6) Inclusion of qualitative data in addition to
2 quantitative data.

3 (7) Technical assistance for providers for completing
4 cost reports including initial training by the Department
5 for providers.

6 (8) Implementation of a timeline which allows an
7 initial grace period for providers to adjust internal
8 procedures and data collection.

9 Details from collected cost reports shall be made publicly
10 available on the Department's website and costs shall be used
11 to ensure the effectiveness and efficiency of Illinois
12 Medicaid rates.

13 (c) Reporting; access to substance use disorder treatment
14 services and recovery supports. By no later than April 1,
15 2024, the Department of Healthcare and Family Services, with
16 input from the Department of Human Services' Division of
17 Substance Use Prevention and Recovery, shall submit a report
18 to the General Assembly regarding access to treatment services
19 and recovery supports for persons diagnosed with a substance
20 use disorder. The report shall include, but is not limited to,
21 the following information:

22 (1) The number of providers enrolled in the Illinois
23 Medical Assistance Program certified to provide substance
24 use disorder treatment services, aggregated by ASAM level
25 of care, and recovery supports.

26 (2) The number of Medicaid customers in Illinois with

1 a diagnosed substance use disorder receiving substance use
2 disorder treatment, aggregated by provider type and ASAM
3 level of care.

4 (3) A comparison of Illinois' substance use disorder
5 licensure and certification requirements with those of
6 comparable state Medicaid programs.

7 (4) Recommendations for and an analysis of the impact
8 of aligning reimbursement rates for outpatient substance
9 use disorder treatment services with reimbursement rates
10 for community-based mental health treatment services.

11 (5) Recommendations for expanding substance use
12 disorder treatment to other qualified provider entities
13 and licensed professionals of the healing arts. The
14 recommendations shall include an analysis of the
15 opportunities to maximize the flexibilities permitted by
16 the federal Centers for Medicare and Medicaid Services for
17 expanding access to the number and types of qualified
18 substance use disorder providers.

19 ARTICLE 10.

20 Section 10-1. The Illinois Administrative Procedure Act is
21 amended by adding Section 5-45.36 as follows:

22 (5 ILCS 100/5-45.36 new)

23 Sec. 5-45.36. Emergency rulemaking; Medicaid reimbursement

1 rates for hospital inpatient and outpatient services. To
2 provide for the expeditious and timely implementation of the
3 changes made by this amendatory Act of the 103rd General
4 Assembly to Sections 5-5.05, 14-12, 14-12.5, and 14-12.7 of
5 the Illinois Public Aid Code, emergency rules implementing the
6 changes made by this amendatory Act of the 103rd General
7 Assembly to Sections 5-5.05, 14-12, 14-12.5, and 14-12.7 of
8 the Illinois Public Aid Code may be adopted in accordance with
9 Section 5-45 by the Department of Healthcare and Family
10 Services. The adoption of emergency rules authorized by
11 Section 5-45 and this Section is deemed to be necessary for the
12 public interest, safety, and welfare.

13 This Section is repealed one year after the effective date
14 of this amendatory Act of the 103rd General Assembly.

15 Section 10-5. The Illinois Public Aid Code is amended by
16 changing Sections 5-5.05, 5A-12.7, 12-4.105, and 14-12 and by
17 adding Sections 14-12.5 and 14-12.7 as follows:

18 (305 ILCS 5/5-5.05)

19 Sec. 5-5.05. Hospitals; psychiatric services.

20 (a) On and after January 1, 2024 ~~July 1, 2008~~, the
21 inpatient, per diem rate to be paid to a hospital for inpatient
22 psychiatric services shall be not less than 90% of the per diem
23 rate established in accordance with paragraph (b-5) of this
24 section, subject to the provisions of Section 14-12.5 ~~§363.77~~.

1 (b) For purposes of this Section, "hospital" means a ~~the~~
2 ~~following:~~

3 ~~(1) Advocate Christ Hospital, Oak Lawn, Illinois.~~

4 ~~(2) Barnes Jewish Hospital, St. Louis, Missouri.~~

5 ~~(3) BroMenn Healthcare, Bloomington, Illinois.~~

6 ~~(4) Jackson Park Hospital, Chicago, Illinois.~~

7 ~~(5) Katherine Shaw Bethea Hospital, Dixon, Illinois.~~

8 ~~(6) Lawrence County Memorial Hospital, Lawrenceville,~~
9 ~~Illinois.~~

10 ~~(7) Advocate Lutheran General Hospital, Park Ridge,~~
11 ~~Illinois.~~

12 ~~(8) Mercy Hospital and Medical Center, Chicago,~~
13 ~~Illinois.~~

14 ~~(9) Methodist Medical Center of Illinois, Peoria,~~
15 ~~Illinois.~~

16 ~~(10) Provena United Samaritans Medical Center,~~
17 ~~Danville, Illinois.~~

18 ~~(11) Rockford Memorial Hospital, Rockford, Illinois.~~

19 ~~(12) Sarah Bush Lincoln Health Center, Mattoon,~~
20 ~~Illinois.~~

21 ~~(13) Provena Covenant Medical Center, Urbana,~~
22 ~~Illinois.~~

23 ~~(14) Rush Presbyterian St. Luke's Medical Center,~~
24 ~~Chicago, Illinois.~~

25 ~~(15) Mt. Sinai Hospital, Chicago, Illinois.~~

26 ~~(16) Gateway Regional Medical Center, Granite City,~~

1 ~~Illinois.~~

2 ~~(17) St. Mary of Nazareth Hospital, Chicago, Illinois.~~

3 ~~(18) Provena St. Mary's Hospital, Kankakee, Illinois.~~

4 ~~(19) St. Mary's Hospital, Decatur, Illinois.~~

5 ~~(20) Memorial Hospital, Belleville, Illinois.~~

6 ~~(21) Swedish Covenant Hospital, Chicago, Illinois.~~

7 ~~(22) Trinity Medical Center, Rock Island, Illinois.~~

8 ~~(23) St. Elizabeth Hospital, Chicago, Illinois.~~

9 ~~(24) Richland Memorial Hospital, Olney, Illinois.~~

10 ~~(25) St. Elizabeth's Hospital, Belleville, Illinois.~~

11 ~~(26) Samaritan Health System, Clinton, Iowa.~~

12 ~~(27) St. John's Hospital, Springfield, Illinois.~~

13 ~~(28) St. Mary's Hospital, Centralia, Illinois.~~

14 ~~(29) Loretto Hospital, Chicago, Illinois.~~

15 ~~(30) Kenneth Hall Regional Hospital, East St. Louis,~~

16 ~~Illinois.~~

17 ~~(31) Hinsdale Hospital, Hinsdale, Illinois.~~

18 ~~(32) Pekin Hospital, Pekin, Illinois.~~

19 ~~(33) University of Chicago Medical Center, Chicago,~~

20 ~~Illinois.~~

21 ~~(34) St. Anthony's Health Center, Alton, Illinois.~~

22 ~~(35) OSF St. Francis Medical Center, Peoria, Illinois.~~

23 ~~(36) Memorial Medical Center, Springfield, Illinois.~~

24 ~~(37) A hospital with a distinct part unit for~~
25 ~~psychiatric services that begins operating on or after~~
26 ~~July 1, 2008.~~

1 For purposes of this Section, "inpatient psychiatric
2 services" means those services provided to patients who are in
3 need of short-term acute inpatient hospitalization for active
4 treatment of an emotional or mental disorder.

5 (b-5) Notwithstanding any other provision of this Section,
6 ~~and subject to appropriation,~~ the inpatient, per diem rate to
7 be paid to all safety-net hospitals for inpatient psychiatric
8 services on and after January 1, 2021 shall be at least \$630,
9 subject to the provisions of Section 14-12.5.

10 (b-10) Notwithstanding any other provision of this
11 Section, effective with dates of service on and after January
12 1, 2022, any general acute care hospital with more than 9,500
13 inpatient psychiatric Medicaid days in any calendar year shall
14 be paid the inpatient per diem rate of no less than \$630,
15 subject to the provisions of Section 14-12.5.

16 (c) No rules shall be promulgated to implement this
17 Section. For purposes of this Section, "rules" is given the
18 meaning contained in Section 1-70 of the Illinois
19 Administrative Procedure Act.

20 (d) (Blank). ~~This Section shall not be in effect during
21 any period of time that the State has in place a fully
22 operational hospital assessment plan that has been approved by
23 the Centers for Medicare and Medicaid Services of the U.S.
24 Department of Health and Human Services.~~

25 (e) On and after July 1, 2012, the Department shall reduce
26 any rate of reimbursement for services or other payments or

1 alter any methodologies authorized by this Code to reduce any
2 rate of reimbursement for services or other payments in
3 accordance with Section 5-5e.

4 (Source: P.A. 102-4, eff. 4-27-21; 102-674, eff. 11-30-21.)

5 (305 ILCS 5/5A-12.7)

6 (Section scheduled to be repealed on December 31, 2026)

7 Sec. 5A-12.7. Continuation of hospital access payments on
8 and after July 1, 2020.

9 (a) To preserve and improve access to hospital services,
10 for hospital services rendered on and after July 1, 2020, the
11 Department shall, except for hospitals described in subsection
12 (b) of Section 5A-3, make payments to hospitals or require
13 capitated managed care organizations to make payments as set
14 forth in this Section. Payments under this Section are not due
15 and payable, however, until: (i) the methodologies described
16 in this Section are approved by the federal government in an
17 appropriate State Plan amendment or directed payment preprint;
18 and (ii) the assessment imposed under this Article is
19 determined to be a permissible tax under Title XIX of the
20 Social Security Act. In determining the hospital access
21 payments authorized under subsection (g) of this Section, if a
22 hospital ceases to qualify for payments from the pool, the
23 payments for all hospitals continuing to qualify for payments
24 from such pool shall be uniformly adjusted to fully expend the
25 aggregate net amount of the pool, with such adjustment being

1 effective on the first day of the second month following the
2 date the hospital ceases to receive payments from such pool.

3 (b) Amounts moved into claims-based rates and distributed
4 in accordance with Section 14-12 shall remain in those
5 claims-based rates.

6 (c) Graduate medical education.

7 (1) The calculation of graduate medical education
8 payments shall be based on the hospital's Medicare cost
9 report ending in Calendar Year 2018, as reported in the
10 Healthcare Cost Report Information System file, release
11 date September 30, 2019. An Illinois hospital reporting
12 intern and resident cost on its Medicare cost report shall
13 be eligible for graduate medical education payments.

14 (2) Each hospital's annualized Medicaid Intern
15 Resident Cost is calculated using annualized intern and
16 resident total costs obtained from Worksheet B Part I,
17 Columns 21 and 22 the sum of Lines 30-43, 50-76, 90-93,
18 96-98, and 105-112 multiplied by the percentage that the
19 hospital's Medicaid days (Worksheet S3 Part I, Column 7,
20 Lines 2, 3, 4, 14, 16-18, and 32) comprise of the
21 hospital's total days (Worksheet S3 Part I, Column 8,
22 Lines 14, 16-18, and 32).

23 (3) An annualized Medicaid indirect medical education
24 (IME) payment is calculated for each hospital using its
25 IME payments (Worksheet E Part A, Line 29, Column 1)
26 multiplied by the percentage that its Medicaid days

1 (Worksheet S3 Part I, Column 7, Lines 2, 3, 4, 14, 16-18,
2 and 32) comprise of its Medicare days (Worksheet S3 Part
3 I, Column 6, Lines 2, 3, 4, 14, and 16-18).

4 (4) For each hospital, its annualized Medicaid Intern
5 Resident Cost and its annualized Medicaid IME payment are
6 summed, and, except as capped at 120% of the average cost
7 per intern and resident for all qualifying hospitals as
8 calculated under this paragraph, is multiplied by the
9 applicable reimbursement factor as described in this
10 paragraph, to determine the hospital's final graduate
11 medical education payment. Each hospital's average cost
12 per intern and resident shall be calculated by summing its
13 total annualized Medicaid Intern Resident Cost plus its
14 annualized Medicaid IME payment and dividing that amount
15 by the hospital's total Full Time Equivalent Residents and
16 Interns. If the hospital's average per intern and resident
17 cost is greater than 120% of the same calculation for all
18 qualifying hospitals, the hospital's per intern and
19 resident cost shall be capped at 120% of the average cost
20 for all qualifying hospitals.

21 (A) For the period of July 1, 2020 through
22 December 31, 2022, the applicable reimbursement factor
23 shall be 22.6%.

24 (B) For the period of January 1, 2023 through
25 December 31, 2026, the applicable reimbursement factor
26 shall be 35% for all qualified safety-net hospitals,

1 as defined in Section 5-5e.1 of this Code, and all
2 hospitals with 100 or more Full Time Equivalent
3 Residents and Interns, as reported on the hospital's
4 Medicare cost report ending in Calendar Year 2018, and
5 for all other qualified hospitals the applicable
6 reimbursement factor shall be 30%.

7 (d) Fee-for-service supplemental payments. For the period
8 of July 1, 2020 through December 31, 2022, each Illinois
9 hospital shall receive an annual payment equal to the amounts
10 below, to be paid in 12 equal installments on or before the
11 seventh State business day of each month, except that no
12 payment shall be due within 30 days after the later of the date
13 of notification of federal approval of the payment
14 methodologies required under this Section or any waiver
15 required under 42 CFR 433.68, at which time the sum of amounts
16 required under this Section prior to the date of notification
17 is due and payable.

18 (1) For critical access hospitals, \$385 per covered
19 inpatient day contained in paid fee-for-service claims and
20 \$530 per paid fee-for-service outpatient claim for dates
21 of service in Calendar Year 2019 in the Department's
22 Enterprise Data Warehouse as of May 11, 2020.

23 (2) For safety-net hospitals, \$960 per covered
24 inpatient day contained in paid fee-for-service claims and
25 \$625 per paid fee-for-service outpatient claim for dates
26 of service in Calendar Year 2019 in the Department's

1 Enterprise Data Warehouse as of May 11, 2020.

2 (3) For long term acute care hospitals, \$295 per
3 covered inpatient day contained in paid fee-for-service
4 claims for dates of service in Calendar Year 2019 in the
5 Department's Enterprise Data Warehouse as of May 11, 2020.

6 (4) For freestanding psychiatric hospitals, \$125 per
7 covered inpatient day contained in paid fee-for-service
8 claims and \$130 per paid fee-for-service outpatient claim
9 for dates of service in Calendar Year 2019 in the
10 Department's Enterprise Data Warehouse as of May 11, 2020.

11 (5) For freestanding rehabilitation hospitals, \$355
12 per covered inpatient day contained in paid
13 fee-for-service claims for dates of service in Calendar
14 Year 2019 in the Department's Enterprise Data Warehouse as
15 of May 11, 2020.

16 (6) For all general acute care hospitals and high
17 Medicaid hospitals as defined in subsection (f), \$350 per
18 covered inpatient day for dates of service in Calendar
19 Year 2019 contained in paid fee-for-service claims and
20 \$620 per paid fee-for-service outpatient claim in the
21 Department's Enterprise Data Warehouse as of May 11, 2020.

22 (7) Alzheimer's treatment access payment. Each
23 Illinois academic medical center or teaching hospital, as
24 defined in Section 5-5e.2 of this Code, that is identified
25 as the primary hospital affiliate of one of the Regional
26 Alzheimer's Disease Assistance Centers, as designated by

1 the Alzheimer's Disease Assistance Act and identified in
2 the Department of Public Health's Alzheimer's Disease
3 State Plan dated December 2016, shall be paid an
4 Alzheimer's treatment access payment equal to the product
5 of the qualifying hospital's State Fiscal Year 2018 total
6 inpatient fee-for-service days multiplied by the
7 applicable Alzheimer's treatment rate of \$226.30 for
8 hospitals located in Cook County and \$116.21 for hospitals
9 located outside Cook County.

10 (d-2) Fee-for-service supplemental payments. Beginning
11 January 1, 2023, each Illinois hospital shall receive an
12 annual payment equal to the amounts listed below, to be paid in
13 12 equal installments on or before the seventh State business
14 day of each month, except that no payment shall be due within
15 30 days after the later of the date of notification of federal
16 approval of the payment methodologies required under this
17 Section or any waiver required under 42 CFR 433.68, at which
18 time the sum of amounts required under this Section prior to
19 the date of notification is due and payable. The Department
20 may adjust the rates in paragraphs (1) through (7) to comply
21 with the federal upper payment limits, with such adjustments
22 being determined so that the total estimated spending by
23 hospital class, under such adjusted rates, remains
24 substantially similar to the total estimated spending under
25 the original rates set forth in this subsection.

26 (1) For critical access hospitals, as defined in

1 subsection (f), \$750 per covered inpatient day contained
2 in paid fee-for-service claims and \$750 per paid
3 fee-for-service outpatient claim for dates of service in
4 Calendar Year 2019 in the Department's Enterprise Data
5 Warehouse as of August 6, 2021.

6 (2) For safety-net hospitals, as described in
7 subsection (f), \$1,350 per inpatient day contained in paid
8 fee-for-service claims and \$1,350 per paid fee-for-service
9 outpatient claim for dates of service in Calendar Year
10 2019 in the Department's Enterprise Data Warehouse as of
11 August 6, 2021.

12 (3) For long term acute care hospitals, \$550 per
13 covered inpatient day contained in paid fee-for-service
14 claims for dates of service in Calendar Year 2019 in the
15 Department's Enterprise Data Warehouse as of August 6,
16 2021.

17 (4) For freestanding psychiatric hospitals, \$200 per
18 covered inpatient day contained in paid fee-for-service
19 claims and \$200 per paid fee-for-service outpatient claim
20 for dates of service in Calendar Year 2019 in the
21 Department's Enterprise Data Warehouse as of August 6,
22 2021.

23 (5) For freestanding rehabilitation hospitals, \$550
24 per covered inpatient day contained in paid
25 fee-for-service claims and \$125 per paid fee-for-service
26 outpatient claim for dates of service in Calendar Year

1 2019 in the Department's Enterprise Data Warehouse as of
2 August 6, 2021.

3 (6) For all general acute care hospitals and high
4 Medicaid hospitals as defined in subsection (f), \$500 per
5 covered inpatient day for dates of service in Calendar
6 Year 2019 contained in paid fee-for-service claims and
7 \$500 per paid fee-for-service outpatient claim in the
8 Department's Enterprise Data Warehouse as of August 6,
9 2021.

10 (7) For public hospitals, as defined in subsection
11 (f), \$275 per covered inpatient day contained in paid
12 fee-for-service claims and \$275 per paid fee-for-service
13 outpatient claim for dates of service in Calendar Year
14 2019 in the Department's Enterprise Data Warehouse as of
15 August 6, 2021.

16 (8) Alzheimer's treatment access payment. Each
17 Illinois academic medical center or teaching hospital, as
18 defined in Section 5-5e.2 of this Code, that is identified
19 as the primary hospital affiliate of one of the Regional
20 Alzheimer's Disease Assistance Centers, as designated by
21 the Alzheimer's Disease Assistance Act and identified in
22 the Department of Public Health's Alzheimer's Disease
23 State Plan dated December 2016, shall be paid an
24 Alzheimer's treatment access payment equal to the product
25 of the qualifying hospital's Calendar Year 2019 total
26 inpatient fee-for-service days, in the Department's

1 Enterprise Data Warehouse as of August 6, 2021, multiplied
2 by the applicable Alzheimer's treatment rate of \$244.37
3 for hospitals located in Cook County and \$312.03 for
4 hospitals located outside Cook County.

5 (e) The Department shall require managed care
6 organizations (MCOs) to make directed payments and
7 pass-through payments according to this Section. Each calendar
8 year, the Department shall require MCOs to pay the maximum
9 amount out of these funds as allowed as pass-through payments
10 under federal regulations. The Department shall require MCOs
11 to make such pass-through payments as specified in this
12 Section. The Department shall require the MCOs to pay the
13 remaining amounts as directed Payments as specified in this
14 Section. The Department shall issue payments to the
15 Comptroller by the seventh business day of each month for all
16 MCOs that are sufficient for MCOs to make the directed
17 payments and pass-through payments according to this Section.
18 The Department shall require the MCOs to make pass-through
19 payments and directed payments using electronic funds
20 transfers (EFT), if the hospital provides the information
21 necessary to process such EFTs, in accordance with directions
22 provided monthly by the Department, within 7 business days of
23 the date the funds are paid to the MCOs, as indicated by the
24 "Paid Date" on the website of the Office of the Comptroller if
25 the funds are paid by EFT and the MCOs have received directed
26 payment instructions. If funds are not paid through the

1 Comptroller by EFT, payment must be made within 7 business
2 days of the date actually received by the MCO. The MCO will be
3 considered to have paid the pass-through payments when the
4 payment remittance number is generated or the date the MCO
5 sends the check to the hospital, if EFT information is not
6 supplied. If an MCO is late in paying a pass-through payment or
7 directed payment as required under this Section (including any
8 extensions granted by the Department), it shall pay a penalty,
9 unless waived by the Department for reasonable cause, to the
10 Department equal to 5% of the amount of the pass-through
11 payment or directed payment not paid on or before the due date
12 plus 5% of the portion thereof remaining unpaid on the last day
13 of each 30-day period thereafter. Payments to MCOs that would
14 be paid consistent with actuarial certification and enrollment
15 in the absence of the increased capitation payments under this
16 Section shall not be reduced as a consequence of payments made
17 under this subsection. The Department shall publish and
18 maintain on its website for a period of no less than 8 calendar
19 quarters, the quarterly calculation of directed payments and
20 pass-through payments owed to each hospital from each MCO. All
21 calculations and reports shall be posted no later than the
22 first day of the quarter for which the payments are to be
23 issued.

24 (f) (1) For purposes of allocating the funds included in
25 capitation payments to MCOs, Illinois hospitals shall be
26 divided into the following classes as defined in

1 administrative rules:

2 (A) Beginning July 1, 2020 through December 31, 2022,
3 critical access hospitals. Beginning January 1, 2023,
4 "critical access hospital" means a hospital designated by
5 the Department of Public Health as a critical access
6 hospital, excluding any hospital meeting the definition of
7 a public hospital in subparagraph (F).

8 (B) Safety-net hospitals, except that stand-alone
9 children's hospitals that are not specialty children's
10 hospitals will not be included. For the calendar year
11 beginning January 1, 2023, and each calendar year
12 thereafter, assignment to the safety-net class shall be
13 based on the annual safety-net rate year beginning 15
14 months before the beginning of the first Payout Quarter of
15 the calendar year.

16 (C) Long term acute care hospitals.

17 (D) Freestanding psychiatric hospitals.

18 (E) Freestanding rehabilitation hospitals.

19 (F) Beginning January 1, 2023, "public hospital" means
20 a hospital that is owned or operated by an Illinois
21 Government body or municipality, excluding a hospital
22 provider that is a State agency, a State university, or a
23 county with a population of 3,000,000 or more.

24 (G) High Medicaid hospitals.

25 (i) As used in this Section, "high Medicaid
26 hospital" means a general acute care hospital that:

1 (I) For the payout periods July 1, 2020
2 through December 31, 2022, is not a safety-net
3 hospital or critical access hospital and that has
4 a Medicaid Inpatient Utilization Rate above 30% or
5 a hospital that had over 35,000 inpatient Medicaid
6 days during the applicable period. For the period
7 July 1, 2020 through December 31, 2020, the
8 applicable period for the Medicaid Inpatient
9 Utilization Rate (MIUR) is the rate year 2020 MIUR
10 and for the number of inpatient days it is State
11 fiscal year 2018. Beginning in calendar year 2021,
12 the Department shall use the most recently
13 determined MIUR, as defined in subsection (h) of
14 Section 5-5.02, and for the inpatient day
15 threshold, the State fiscal year ending 18 months
16 prior to the beginning of the calendar year. For
17 purposes of calculating MIUR under this Section,
18 children's hospitals and affiliated general acute
19 care hospitals shall be considered a single
20 hospital.

21 (II) For the calendar year beginning January
22 1, 2023, and each calendar year thereafter, is not
23 a public hospital, safety-net hospital, or
24 critical access hospital and that qualifies as a
25 regional high volume hospital or is a hospital
26 that has a Medicaid Inpatient Utilization Rate

1 (MIUR) above 30%. As used in this item, "regional
2 high volume hospital" means a hospital which ranks
3 in the top 2 quartiles based on total hospital
4 services volume, of all eligible general acute
5 care hospitals, when ranked in descending order
6 based on total hospital services volume, within
7 the same Medicaid managed care region, as
8 designated by the Department, as of January 1,
9 2022. As used in this item, "total hospital
10 services volume" means the total of all Medical
11 Assistance hospital inpatient admissions plus all
12 Medical Assistance hospital outpatient visits. For
13 purposes of determining regional high volume
14 hospital inpatient admissions and outpatient
15 visits, the Department shall use dates of service
16 provided during State Fiscal Year 2020 for the
17 Payout Quarter beginning January 1, 2023. The
18 Department shall use dates of service from the
19 State fiscal year ending 18 month before the
20 beginning of the first Payout Quarter of the
21 subsequent annual determination period.

22 (ii) For the calendar year beginning January 1,
23 2023, the Department shall use the Rate Year 2022
24 Medicaid inpatient utilization rate (MIUR), as defined
25 in subsection (h) of Section 5-5.02. For each
26 subsequent annual determination, the Department shall

1 use the MIUR applicable to the rate year ending
2 September 30 of the year preceding the beginning of
3 the calendar year.

4 (H) General acute care hospitals. As used under this
5 Section, "general acute care hospitals" means all other
6 Illinois hospitals not identified in subparagraphs (A)
7 through (G).

8 (2) Hospitals' qualification for each class shall be
9 assessed prior to the beginning of each calendar year and the
10 new class designation shall be effective January 1 of the next
11 year. The Department shall publish by rule the process for
12 establishing class determination.

13 (3) Beginning January 1, 2024, the Department may reassign
14 hospitals or entire hospital classes as defined above, if
15 federal limits on the payments to the class to which the
16 hospitals are assigned based on the criteria in this
17 subsection prevent the Department from making payments to the
18 class that would otherwise be due under this Section. The
19 Department shall publish the criteria and composition of each
20 new class based on the reassignments, and the projected impact
21 on payments to each hospital under the new classes on its
22 website by November 15 of the year before the year in which the
23 class changes become effective.

24 (g) Fixed pool directed payments. Beginning July 1, 2020,
25 the Department shall issue payments to MCOs which shall be
26 used to issue directed payments to qualified Illinois

1 safety-net hospitals and critical access hospitals on a
2 monthly basis in accordance with this subsection. Prior to the
3 beginning of each Payout Quarter beginning July 1, 2020, the
4 Department shall use encounter claims data from the
5 Determination Quarter, accepted by the Department's Medicaid
6 Management Information System for inpatient and outpatient
7 services rendered by safety-net hospitals and critical access
8 hospitals to determine a quarterly uniform per unit add-on for
9 each hospital class.

10 (1) Inpatient per unit add-on. A quarterly uniform per
11 diem add-on shall be derived by dividing the quarterly
12 Inpatient Directed Payments Pool amount allocated to the
13 applicable hospital class by the total inpatient days
14 contained on all encounter claims received during the
15 Determination Quarter, for all hospitals in the class.

16 (A) Each hospital in the class shall have a
17 quarterly inpatient directed payment calculated that
18 is equal to the product of the number of inpatient days
19 attributable to the hospital used in the calculation
20 of the quarterly uniform class per diem add-on,
21 multiplied by the calculated applicable quarterly
22 uniform class per diem add-on of the hospital class.

23 (B) Each hospital shall be paid 1/3 of its
24 quarterly inpatient directed payment in each of the 3
25 months of the Payout Quarter, in accordance with
26 directions provided to each MCO by the Department.

1 (2) Outpatient per unit add-on. A quarterly uniform
2 per claim add-on shall be derived by dividing the
3 quarterly Outpatient Directed Payments Pool amount
4 allocated to the applicable hospital class by the total
5 outpatient encounter claims received during the
6 Determination Quarter, for all hospitals in the class.

7 (A) Each hospital in the class shall have a
8 quarterly outpatient directed payment calculated that
9 is equal to the product of the number of outpatient
10 encounter claims attributable to the hospital used in
11 the calculation of the quarterly uniform class per
12 claim add-on, multiplied by the calculated applicable
13 quarterly uniform class per claim add-on of the
14 hospital class.

15 (B) Each hospital shall be paid 1/3 of its
16 quarterly outpatient directed payment in each of the 3
17 months of the Payout Quarter, in accordance with
18 directions provided to each MCO by the Department.

19 (3) Each MCO shall pay each hospital the Monthly
20 Directed Payment as identified by the Department on its
21 quarterly determination report.

22 (4) Definitions. As used in this subsection:

23 (A) "Payout Quarter" means each 3 month calendar
24 quarter, beginning July 1, 2020.

25 (B) "Determination Quarter" means each 3 month
26 calendar quarter, which ends 3 months prior to the

1 first day of each Payout Quarter.

2 (5) For the period July 1, 2020 through December 2020,
3 the following amounts shall be allocated to the following
4 hospital class directed payment pools for the quarterly
5 development of a uniform per unit add-on:

6 (A) \$2,894,500 for hospital inpatient services for
7 critical access hospitals.

8 (B) \$4,294,374 for hospital outpatient services
9 for critical access hospitals.

10 (C) \$29,109,330 for hospital inpatient services
11 for safety-net hospitals.

12 (D) \$35,041,218 for hospital outpatient services
13 for safety-net hospitals.

14 (6) For the period January 1, 2023 through December
15 31, 2023, the Department shall establish the amounts that
16 shall be allocated to the hospital class directed payment
17 fixed pools identified in this paragraph for the quarterly
18 development of a uniform per unit add-on. The Department
19 shall establish such amounts so that the total amount of
20 payments to each hospital under this Section in calendar
21 year 2023 is projected to be substantially similar to the
22 total amount of such payments received by the hospital
23 under this Section in calendar year 2021, adjusted for
24 increased funding provided for fixed pool directed
25 payments under subsection (g) in calendar year 2022,
26 assuming that the volume and acuity of claims are held

1 constant. The Department shall publish the directed
2 payment fixed pool amounts to be established under this
3 paragraph on its website by November 15, 2022.

4 (A) Hospital inpatient services for critical
5 access hospitals.

6 (B) Hospital outpatient services for critical
7 access hospitals.

8 (C) Hospital inpatient services for public
9 hospitals.

10 (D) Hospital outpatient services for public
11 hospitals.

12 (E) Hospital inpatient services for safety-net
13 hospitals.

14 (F) Hospital outpatient services for safety-net
15 hospitals.

16 (7) Semi-annual rate maintenance review. The
17 Department shall ensure that hospitals assigned to the
18 fixed pools in paragraph (6) are paid no less than 95% of
19 the annual initial rate for each 6-month period of each
20 annual payout period. For each calendar year, the
21 Department shall calculate the annual initial rate per day
22 and per visit for each fixed pool hospital class listed in
23 paragraph (6), by dividing the total of all applicable
24 inpatient or outpatient directed payments issued in the
25 preceding calendar year to the hospitals in each fixed
26 pool class for the calendar year, plus any increase

1 resulting from the annual adjustments described in
2 subsection (i), by the actual applicable total service
3 units for the preceding calendar year which were the basis
4 of the total applicable inpatient or outpatient directed
5 payments issued to the hospitals in each fixed pool class
6 in the calendar year, except that for calendar year 2023,
7 the service units from calendar year 2021 shall be used.

8 (A) The Department shall calculate the effective
9 rate, per day and per visit, for the payout periods of
10 January to June and July to December of each year, for
11 each fixed pool listed in paragraph (6), by dividing
12 50% of the annual pool by the total applicable
13 reported service units for the 2 applicable
14 determination quarters.

15 (B) If the effective rate calculated in
16 subparagraph (A) is less than 95% of the annual
17 initial rate assigned to the class for each pool under
18 paragraph (6), the Department shall adjust the payment
19 for each hospital to a level equal to no less than 95%
20 of the annual initial rate, by issuing a retroactive
21 adjustment payment for the 6-month period under review
22 as identified in subparagraph (A).

23 (h) Fixed rate directed payments. Effective July 1, 2020,
24 the Department shall issue payments to MCOs which shall be
25 used to issue directed payments to Illinois hospitals not
26 identified in paragraph (g) on a monthly basis. Prior to the

1 beginning of each Payout Quarter beginning July 1, 2020, the
2 Department shall use encounter claims data from the
3 Determination Quarter, accepted by the Department's Medicaid
4 Management Information System for inpatient and outpatient
5 services rendered by hospitals in each hospital class
6 identified in paragraph (f) and not identified in paragraph
7 (g). For the period July 1, 2020 through December 2020, the
8 Department shall direct MCOs to make payments as follows:

9 (1) For general acute care hospitals an amount equal
10 to \$1,750 multiplied by the hospital's category of service
11 20 case mix index for the determination quarter multiplied
12 by the hospital's total number of inpatient admissions for
13 category of service 20 for the determination quarter.

14 (2) For general acute care hospitals an amount equal
15 to \$160 multiplied by the hospital's category of service
16 21 case mix index for the determination quarter multiplied
17 by the hospital's total number of inpatient admissions for
18 category of service 21 for the determination quarter.

19 (3) For general acute care hospitals an amount equal
20 to \$80 multiplied by the hospital's category of service 22
21 case mix index for the determination quarter multiplied by
22 the hospital's total number of inpatient admissions for
23 category of service 22 for the determination quarter.

24 (4) For general acute care hospitals an amount equal
25 to \$375 multiplied by the hospital's category of service
26 24 case mix index for the determination quarter multiplied

1 by the hospital's total number of category of service 24
2 paid EAPG (EAPGs) for the determination quarter.

3 (5) For general acute care hospitals an amount equal
4 to \$240 multiplied by the hospital's category of service
5 27 and 28 case mix index for the determination quarter
6 multiplied by the hospital's total number of category of
7 service 27 and 28 paid EAPGs for the determination
8 quarter.

9 (6) For general acute care hospitals an amount equal
10 to \$290 multiplied by the hospital's category of service
11 29 case mix index for the determination quarter multiplied
12 by the hospital's total number of category of service 29
13 paid EAPGs for the determination quarter.

14 (7) For high Medicaid hospitals an amount equal to
15 \$1,800 multiplied by the hospital's category of service 20
16 case mix index for the determination quarter multiplied by
17 the hospital's total number of inpatient admissions for
18 category of service 20 for the determination quarter.

19 (8) For high Medicaid hospitals an amount equal to
20 \$160 multiplied by the hospital's category of service 21
21 case mix index for the determination quarter multiplied by
22 the hospital's total number of inpatient admissions for
23 category of service 21 for the determination quarter.

24 (9) For high Medicaid hospitals an amount equal to \$80
25 multiplied by the hospital's category of service 22 case
26 mix index for the determination quarter multiplied by the

1 hospital's total number of inpatient admissions for
2 category of service 22 for the determination quarter.

3 (10) For high Medicaid hospitals an amount equal to
4 \$400 multiplied by the hospital's category of service 24
5 case mix index for the determination quarter multiplied by
6 the hospital's total number of category of service 24 paid
7 EAPG outpatient claims for the determination quarter.

8 (11) For high Medicaid hospitals an amount equal to
9 \$240 multiplied by the hospital's category of service 27
10 and 28 case mix index for the determination quarter
11 multiplied by the hospital's total number of category of
12 service 27 and 28 paid EAPGs for the determination
13 quarter.

14 (12) For high Medicaid hospitals an amount equal to
15 \$290 multiplied by the hospital's category of service 29
16 case mix index for the determination quarter multiplied by
17 the hospital's total number of category of service 29 paid
18 EAPGs for the determination quarter.

19 (13) For long term acute care hospitals the amount of
20 \$495 multiplied by the hospital's total number of
21 inpatient days for the determination quarter.

22 (14) For psychiatric hospitals the amount of \$210
23 multiplied by the hospital's total number of inpatient
24 days for category of service 21 for the determination
25 quarter.

26 (15) For psychiatric hospitals the amount of \$250

1 multiplied by the hospital's total number of outpatient
2 claims for category of service 27 and 28 for the
3 determination quarter.

4 (16) For rehabilitation hospitals the amount of \$410
5 multiplied by the hospital's total number of inpatient
6 days for category of service 22 for the determination
7 quarter.

8 (17) For rehabilitation hospitals the amount of \$100
9 multiplied by the hospital's total number of outpatient
10 claims for category of service 29 for the determination
11 quarter.

12 (18) Effective for the Payout Quarter beginning
13 January 1, 2023, for the directed payments to hospitals
14 required under this subsection, the Department shall
15 establish the amounts that shall be used to calculate such
16 directed payments using the methodologies specified in
17 this paragraph. The Department shall use a single, uniform
18 rate, adjusted for acuity as specified in paragraphs (1)
19 through (12), for all categories of inpatient services
20 provided by each class of hospitals and a single uniform
21 rate, adjusted for acuity as specified in paragraphs (1)
22 through (12), for all categories of outpatient services
23 provided by each class of hospitals. The Department shall
24 establish such amounts so that the total amount of
25 payments to each hospital under this Section in calendar
26 year 2023 is projected to be substantially similar to the

1 total amount of such payments received by the hospital
2 under this Section in calendar year 2021, adjusted for
3 increased funding provided for fixed pool directed
4 payments under subsection (g) in calendar year 2022,
5 assuming that the volume and acuity of claims are held
6 constant. The Department shall publish the directed
7 payment amounts to be established under this subsection on
8 its website by November 15, 2022.

9 (19) Each hospital shall be paid 1/3 of their
10 quarterly inpatient and outpatient directed payment in
11 each of the 3 months of the Payout Quarter, in accordance
12 with directions provided to each MCO by the Department.

13 20 Each MCO shall pay each hospital the Monthly
14 Directed Payment amount as identified by the Department on
15 its quarterly determination report.

16 Notwithstanding any other provision of this subsection, if
17 the Department determines that the actual total hospital
18 utilization data that is used to calculate the fixed rate
19 directed payments is substantially different than anticipated
20 when the rates in this subsection were initially determined
21 for unforeseeable circumstances (such as the COVID-19 pandemic
22 or some other public health emergency), the Department may
23 adjust the rates specified in this subsection so that the
24 total directed payments approximate the total spending amount
25 anticipated when the rates were initially established.

26 Definitions. As used in this subsection:

1 (A) "Payout Quarter" means each calendar quarter,
2 beginning July 1, 2020.

3 (B) "Determination Quarter" means each calendar
4 quarter which ends 3 months prior to the first day of
5 each Payout Quarter.

6 (C) "Case mix index" means a hospital specific
7 calculation. For inpatient claims the case mix index
8 is calculated each quarter by summing the relative
9 weight of all inpatient Diagnosis-Related Group (DRG)
10 claims for a category of service in the applicable
11 Determination Quarter and dividing the sum by the
12 number of sum total of all inpatient DRG admissions
13 for the category of service for the associated claims.
14 The case mix index for outpatient claims is calculated
15 each quarter by summing the relative weight of all
16 paid EAPGs in the applicable Determination Quarter and
17 dividing the sum by the sum total of paid EAPGs for the
18 associated claims.

19 (i) Beginning January 1, 2021, the rates for directed
20 payments shall be recalculated in order to spend the
21 additional funds for directed payments that result from
22 reduction in the amount of pass-through payments allowed under
23 federal regulations. The additional funds for directed
24 payments shall be allocated proportionally to each class of
25 hospitals based on that class' proportion of services.

26 (1) Beginning January 1, 2024, the fixed pool directed

1 payment amounts and the associated annual initial rates
2 referenced in paragraph (6) of subsection (f) for each
3 hospital class shall be uniformly increased by a ratio of
4 not less than, the ratio of the total pass-through
5 reduction amount pursuant to paragraph (4) of subsection
6 (j), for the hospitals comprising the hospital fixed pool
7 directed payment class for the next calendar year, to the
8 total inpatient and outpatient directed payments for the
9 hospitals comprising the hospital fixed pool directed
10 payment class paid during the preceding calendar year.

11 (2) Beginning January 1, 2024, the fixed rates for the
12 directed payments referenced in paragraph (18) of
13 subsection (h) for each hospital class shall be uniformly
14 increased by a ratio of not less than, the ratio of the
15 total pass-through reduction amount pursuant to paragraph
16 (4) of subsection (j), for the hospitals comprising the
17 hospital directed payment class for the next calendar
18 year, to the total inpatient and outpatient directed
19 payments for the hospitals comprising the hospital fixed
20 rate directed payment class paid during the preceding
21 calendar year.

22 (j) Pass-through payments.

23 (1) For the period July 1, 2020 through December 31,
24 2020, the Department shall assign quarterly pass-through
25 payments to each class of hospitals equal to one-fourth of
26 the following annual allocations:

- 1 (A) \$390,487,095 to safety-net hospitals.
- 2 (B) \$62,553,886 to critical access hospitals.
- 3 (C) \$345,021,438 to high Medicaid hospitals.
- 4 (D) \$551,429,071 to general acute care hospitals.
- 5 (E) \$27,283,870 to long term acute care hospitals.
- 6 (F) \$40,825,444 to freestanding psychiatric
7 hospitals.
- 8 (G) \$9,652,108 to freestanding rehabilitation
9 hospitals.
- 10 (2) For the period of July 1, 2020 through December
11 31, 2020, the pass-through payments shall at a minimum
12 ensure hospitals receive a total amount of monthly
13 payments under this Section as received in calendar year
14 2019 in accordance with this Article and paragraph (1) of
15 subsection (d-5) of Section 14-12, exclusive of amounts
16 received through payments referenced in subsection (b).
- 17 (3) For the calendar year beginning January 1, 2023,
18 the Department shall establish the annual pass-through
19 allocation to each class of hospitals and the pass-through
20 payments to each hospital so that the total amount of
21 payments to each hospital under this Section in calendar
22 year 2023 is projected to be substantially similar to the
23 total amount of such payments received by the hospital
24 under this Section in calendar year 2021, adjusted for
25 increased funding provided for fixed pool directed
26 payments under subsection (g) in calendar year 2022,

1 assuming that the volume and acuity of claims are held
2 constant. The Department shall publish the pass-through
3 allocation to each class and the pass-through payments to
4 each hospital to be established under this subsection on
5 its website by November 15, 2022.

6 (4) For the calendar years beginning January 1, 2021
7 ~~and, January 1, 2022, and January 1, 2024, and each~~
8 ~~calendar year thereafter,~~ each hospital's pass-through
9 payment amount shall be reduced proportionally to the
10 reduction of all pass-through payments required by federal
11 regulations. Beginning January 1, 2024, the Department
12 shall reduce total pass-through payments by the minimum
13 amount necessary to comply with federal regulations.
14 Pass-through payments to safety-net hospitals as defined
15 in Section 5-5e.1 of this Code, shall not be reduced until
16 all pass-through payments to other hospitals have been
17 eliminated. All other hospitals shall have their
18 pass-through payments reduced proportionally.

19 (k) At least 30 days prior to each calendar year, the
20 Department shall notify each hospital of changes to the
21 payment methodologies in this Section, including, but not
22 limited to, changes in the fixed rate directed payment rates,
23 the aggregate pass-through payment amount for all hospitals,
24 and the hospital's pass-through payment amount for the
25 upcoming calendar year.

26 (l) Notwithstanding any other provisions of this Section,

1 the Department may adopt rules to change the methodology for
2 directed and pass-through payments as set forth in this
3 Section, but only to the extent necessary to obtain federal
4 approval of a necessary State Plan amendment or Directed
5 Payment Preprint or to otherwise conform to federal law or
6 federal regulation.

7 (m) As used in this subsection, "managed care
8 organization" or "MCO" means an entity which contracts with
9 the Department to provide services where payment for medical
10 services is made on a capitated basis, excluding contracted
11 entities for dual eligible or Department of Children and
12 Family Services youth populations.

13 (n) In order to address the escalating infant mortality
14 rates among minority communities in Illinois, the State shall,
15 subject to appropriation, create a pool of funding of at least
16 \$50,000,000 annually to be disbursed among safety-net
17 hospitals that maintain perinatal designation from the
18 Department of Public Health. The funding shall be used to
19 preserve or enhance OB/GYN services or other specialty
20 services at the receiving hospital, with the distribution of
21 funding to be established by rule and with consideration to
22 perinatal hospitals with safe birthing levels and quality
23 metrics for healthy mothers and babies.

24 (o) In order to address the growing challenges of
25 providing stable access to healthcare in rural Illinois,
26 including perinatal services, behavioral healthcare including

1 substance use disorder services (SUDs) and other specialty
2 services, and to expand access to telehealth services among
3 rural communities in Illinois, the Department of Healthcare
4 and Family Services, ~~subject to appropriation,~~ shall
5 administer a program to provide at least \$10,000,000 in
6 financial support annually to critical access hospitals for
7 delivery of perinatal and OB/GYN services, behavioral
8 healthcare including SUDs, other specialty services and
9 telehealth services. The funding shall be used to preserve or
10 enhance perinatal and OB/GYN services, behavioral healthcare
11 including SUDs, other specialty services, as well as the
12 explanation of telehealth services by the receiving hospital,
13 with the distribution of funding to be established by rule.

14 (p) For calendar year 2023, the final amounts, rates, and
15 payments under subsections (c), (d-2), (g), (h), and (j) shall
16 be established by the Department, so that the sum of the total
17 estimated annual payments under subsections (c), (d-2), (g),
18 (h), and (j) for each hospital class for calendar year 2023, is
19 no less than:

- 20 (1) \$858,260,000 to safety-net hospitals.
- 21 (2) \$86,200,000 to critical access hospitals.
- 22 (3) \$1,765,000,000 to high Medicaid hospitals.
- 23 (4) \$673,860,000 to general acute care hospitals.
- 24 (5) \$48,330,000 to long term acute care hospitals.
- 25 (6) \$89,110,000 to freestanding psychiatric hospitals.
- 26 (7) \$24,300,000 to freestanding rehabilitation

1 hospitals.

2 (8) \$32,570,000 to public hospitals.

3 (q) Hospital Pandemic Recovery Stabilization Payments. The
4 Department shall disburse a pool of \$460,000,000 in stability
5 payments to hospitals prior to April 1, 2023. The allocation
6 of the pool shall be based on the hospital directed payment
7 classes and directed payments issued, during Calendar Year
8 2022 with added consideration to safety net hospitals, as
9 defined in subdivision (f)(1)(B) of this Section, and critical
10 access hospitals.

11 (Source: P.A. 101-650, eff. 7-7-20; 102-4, eff. 4-27-21;
12 102-16, eff. 6-17-21; 102-886, eff. 5-17-22; 102-1115, eff.
13 1-9-23.)

14 (305 ILCS 5/12-4.105)

15 Sec. 12-4.105. Human poison control center; payment
16 program. Subject to funding availability resulting from
17 transfers made from the Hospital Provider Fund to the
18 Healthcare Provider Relief Fund as authorized under this Code,
19 for State fiscal year 2017 and State fiscal year 2018, and for
20 each State fiscal year thereafter in which the assessment
21 under Section 5A-2 is imposed, the Department of Healthcare
22 and Family Services shall pay to the human poison control
23 center designated under the Poison Control System Act an
24 amount of not less than \$3,000,000 for each of State fiscal
25 years 2017 through 2020, and for State fiscal years 2021

1 through 2023 ~~2026~~ an amount of not less than \$3,750,000 and for
2 State fiscal years 2024 through 2026 an amount of not less than
3 \$4,000,000 and for the period July 1, 2026 through December
4 31, 2026 an amount of not less than \$2,000,000 ~~\$1,875,000~~, if
5 the human poison control center is in operation.

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

7 (305 ILCS 5/14-12)

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

11 (a) Inpatient hospital services. Effective for discharges
12 on and after July 1, 2014, reimbursement for inpatient general
13 acute care services shall utilize the All Patient Refined
14 Diagnosis Related Grouping (APR-DRG) software, version 30,
15 distributed by 3MTM Health Information System.

16 (1) The Department shall establish Medicaid weighting
17 factors to be used in the reimbursement system established
18 under this subsection. Initial weighting factors shall be
19 the weighting factors as published by 3M Health
20 Information System, associated with Version 30.0 adjusted
21 for the Illinois experience.

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

1 prior to their effective date.

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

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

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

21 (6) Beginning July 1, 2014 and ending on December 31,
22 2023 ~~June 30, 2024~~, in addition to the
23 statewide-standardized amount, the Department shall
24 develop an adjustor to adjust the rate of reimbursement
25 for safety-net hospitals defined in Section 5-5e.1 of this
26 Code excluding pediatric hospitals.

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

8 (7.5) (Blank).

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

16 (9) Beginning July 1, 2018, in addition to the
17 statewide-standardized amount, the Department shall apply
18 the same adjustor that is applied to trauma cases as of
19 December 31, 2017 to inpatient claims to treat patients
20 with burns, including, but not limited to, APR-DRGs 841,
21 842, 843, and 844.

22 (10) Beginning July 1, 2018, the
23 statewide-standardized amount for inpatient general acute
24 care services shall be uniformly increased so that base
25 claims projected reimbursement is increased by an amount
26 equal to the funds allocated in paragraph (1) of

1 subsection (b) of Section 5A-12.6, less the amount
2 allocated under paragraphs (8) and (9) of this subsection
3 and paragraphs (3) and (4) of subsection (b) multiplied by
4 40%.

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

8 (b) Outpatient hospital services. Effective for dates of
9 service on and after July 1, 2014, reimbursement for
10 outpatient services shall utilize the Enhanced Ambulatory
11 Procedure Grouping (EAPG) software, version 3.7 distributed by
12 3MTM Health Information System.

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

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

21 (A) The initial statewide standardized amounts,
22 with the labor portion adjusted by the Calendar Year
23 2013 Medicare Outpatient Prospective Payment System
24 wage index with reclassifications, shall be published
25 by the Department on its website no later than 10
26 calendar days prior to their effective date.

1 (B) The Department shall establish adjustments to
2 the statewide-standardized amounts for each Critical
3 Access Hospital, as designated by the Department of
4 Public Health in accordance with 42 CFR 485, Subpart
5 F. For outpatient services provided on or before June
6 30, 2018, the EAPG standardized amounts are determined
7 separately for each critical access hospital such that
8 simulated EAPG payments using outpatient base period
9 paid claim data plus payments under Section 5A-12.4 of
10 this Code net of the associated tax costs are equal to
11 the estimated costs of outpatient base period claims
12 data with a rate year cost inflation factor applied.

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

24 (4) Beginning July 1, 2018, in addition to the
25 statewide standardized amounts, the Department shall make
26 an add-on payment for outpatient expensive devices and

1 drugs. This add-on payment shall at least apply to claim
2 lines that: (i) are assigned with one of the following
3 EAPGs: 490, 1001 to 1020, and coded with one of the
4 following revenue codes: 0274 to 0276, 0278; or (ii) are
5 assigned with one of the following EAPGs: 430 to 441, 443,
6 444, 460 to 465, 495, 496, 1090. The add-on payment shall
7 be calculated as follows: the claim line's covered charges
8 multiplied by the hospital's total acute cost to charge
9 ratio, less the claim line's EAPG payment plus \$1,000,
10 multiplied by 0.8.

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

19 (6) Effective for dates of service on or after July 1,
20 2018, the Department shall establish adjustments to the
21 statewide-standardized amounts for each Critical Access
22 Hospital, as designated by the Department of Public Health
23 in accordance with 42 CFR 485, Subpart F, such that each
24 Critical Access Hospital's standardized amount for
25 outpatient services shall be increased by the applicable
26 uniform percentage determined pursuant to paragraph (5) of

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

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

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

1 (2) It is the intent of the General Assembly that
2 the recalculations required under this paragraph (7)
3 by Public Act 100-1181 shall be applied prospectively
4 to claims for dates of service provided on or after
5 March 8, 2019 (the effective date of Public Act
6 100-1181) and that no recoupment or repayment by the
7 Department or an MCO of payments attributable to
8 recalculation under this paragraph (7), issued to the
9 hospital for dates of service on or after July 1, 2018
10 and before March 8, 2019 (the effective date of Public
11 Act 100-1181), shall be permitted.

12 (8) The Department shall ensure that all necessary
13 adjustments to the managed care organization capitation
14 base rates necessitated by the adjustments under
15 subparagraph (6) or (7) of this subsection are completed
16 and applied retroactively in accordance with Section
17 5-30.8 of this Code within 90 days of March 8, 2019 (the
18 effective date of Public Act 100-1181).

19 (9) Within 60 days after federal approval of the
20 change made to the assessment in Section 5A-2 by Public
21 Act 101-650 ~~this amendatory Act of the 101st General~~
22 ~~Assembly~~, the Department shall incorporate into the EAPG
23 system for outpatient services those services performed by
24 hospitals currently billed through the Non-Institutional
25 Provider billing system.

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

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

6 (c) In consultation with the hospital community, the
7 Department is authorized to replace 89 Ill. ~~Adm. Admin.~~ Code
8 152.150 as published in 38 Ill. Reg. 4980 through 4986 within
9 12 months of June 16, 2014 (the effective date of Public Act
10 98-651). If the Department does not replace these rules within
11 12 months of June 16, 2014 (the effective date of Public Act
12 98-651), the rules in effect for 152.150 as published in 38
13 Ill. Reg. 4980 through 4986 shall remain in effect until
14 modified by rule by the Department. Nothing in this subsection
15 shall be construed to mandate that the Department file a
16 replacement rule.

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

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

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

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

22 (1) Phase 1. In State fiscal years 2019 through 2020,
23 the Department shall allocate funds from the transitional
24 access hospital pool to create a hospital transformation
25 pool of at least \$262,906,870 annually and make hospital
26 transformation payments to hospitals. Subject to Section

1 5A-16, in State fiscal years 2019 and 2020, an Illinois
2 hospital that received either a transitional hospital
3 access payment under subsection (d) or a supplemental
4 payment under subsection (f) of this Section in State
5 fiscal year 2018, shall receive a hospital transformation
6 payment as follows:

7 (A) If the hospital's Rate Year 2017 Medicaid
8 inpatient utilization rate is equal to or greater than
9 45%, the hospital transformation payment shall be
10 equal to 100% of the sum of its transitional hospital
11 access payment authorized under subsection (d) and any
12 supplemental payment authorized under subsection (f).

13 (B) If the hospital's Rate Year 2017 Medicaid
14 inpatient utilization rate is equal to or greater than
15 25% but less than 45%, the hospital transformation
16 payment shall be equal to 75% of the sum of its
17 transitional hospital access payment authorized under
18 subsection (d) and any supplemental payment authorized
19 under subsection (f).

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

26 (2) Phase 2.

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

4 (B) Because there are communities in Illinois that
5 experience significant health care disparities due to
6 systemic racism, as recently emphasized by the
7 COVID-19 pandemic, aggravated by social determinants
8 of health and a lack of sufficiently allocated
9 healthcare resources, particularly community-based
10 services, preventive care, obstetric care, chronic
11 disease management, and specialty care, the Department
12 shall establish a health care transformation program
13 that shall be supported by the transformation funding
14 pool. It is the intention of the General Assembly that
15 innovative partnerships funded by the pool must be
16 designed to establish or improve integrated health
17 care delivery systems that will provide significant
18 access to the Medicaid and uninsured populations in
19 their communities, as well as improve health care
20 equity. It is also the intention of the General
21 Assembly that partnerships recognize and address the
22 disparities revealed by the COVID-19 pandemic, as well
23 as the need for post-COVID care. During State fiscal
24 years 2021 through 2027, the hospital and health care
25 transformation program shall be supported by an annual
26 transformation funding pool of up to \$150,000,000,

1 pending federal matching funds, to be allocated during
2 the specified fiscal years for the purpose of
3 facilitating hospital and health care transformation.
4 No disbursement of moneys for transformation projects
5 from the transformation funding pool described under
6 this Section shall be considered an award, a grant, or
7 an expenditure of grant funds. Funding agreements made
8 in accordance with the transformation program shall be
9 considered purchases of care under the Illinois
10 Procurement Code, and funds shall be expended by the
11 Department in a manner that maximizes federal funding
12 to expend the entire allocated amount.

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

1 regional partnership to bring additional specialty
2 services to communities.

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

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

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

25 (i) the proposal shall be designed based on
26 community needs assessment completed by either a

1 University partner or other qualified entity with
2 significant community input;

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

10 (iii) the proposal shall be specifically
11 designed to improve healthcare outcomes and reduce
12 healthcare disparities, and improve the
13 coordination, effectiveness, and efficiency of
14 care delivery;

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

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

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

25 (F) Entities eligible to be funded.

26 (i) Proposals for funding should come from

1 collaborations operating in one of the most
2 distressed communities in Illinois as determined
3 by the U.S. Centers for Disease Control and
4 Prevention's Social Vulnerability Index for
5 Illinois and areas disproportionately impacted by
6 COVID-19 or from rural areas of Illinois.

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

23 (iii) The Department should target the funding
24 in the following ways: \$30,000,000 of
25 transformation funds to projects that are a
26 collaboration between a safety-net hospital,

1 particularly community safety-net hospitals, and
2 other providers and designed to address specific
3 healthcare disparities, \$20,000,000 of
4 transformation funds to collaborations between
5 safety-net hospitals and a larger hospital partner
6 that increases specialty care in distressed
7 communities, \$30,000,000 of transformation funds
8 to projects that are a collaboration between
9 hospitals and other providers in distressed areas
10 of the State designed to address specific
11 healthcare disparities, \$15,000,000 to
12 collaborations between critical access hospitals
13 and other providers designed to address specific
14 healthcare disparities, and \$15,000,000 to
15 cross-provider collaborations designed to address
16 specific healthcare disparities, and \$5,000,000 to
17 collaborations that focus on workforce
18 development.

19 (iv) The Department may allocate up to
20 \$5,000,000 for planning, racial equity analysis,
21 or consulting resources for the Department or
22 entities without the resources to develop a plan
23 to meet the criteria of this Section. Any contract
24 for consulting services issued by the Department
25 under this subparagraph shall comply with the
26 provisions of Section 5-45 of the State Officials

1 and Employees Ethics Act. Based on availability of
2 federal funding, the Department may directly
3 procure consulting services or provide funding to
4 the collaboration. The provision of resources
5 under this subparagraph is not a guarantee that a
6 project will be approved.

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

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

24 (i) A detailed description of how the project
25 intends to affect the goals outlined in this
26 subsection, describing new interventions, new

1 technology, new structures, and other changes to
2 the healthcare delivery system planned.

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

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

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

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

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

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

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

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

26 (x) Documentation of a community input process

1 in the community served, including links to
2 proposal materials on public websites.

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

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

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

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

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

26 (H) The Department shall evaluate proposals for

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

1 milestones or metrics or Business Enterprise Program
2 commitments in its plan. The Department may reduce or
3 end payments, as set forth in transformation plans, if
4 milestones or metrics or Business Enterprise Program
5 commitments are not achieved. The Department shall
6 seek to make payments from the transformation fund in
7 a manner that is eligible for federal matching funds.

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

21 (3) (Blank).

22 (4) Hospital Transformation Review Committee. There is
23 created the Hospital Transformation Review Committee. The
24 Committee shall consist of 14 members. No later than 30
25 days after March 12, 2018 (the effective date of Public
26 Act 100-581), the 4 legislative leaders shall each appoint

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

1 Committee appointed by the legislative leaders shall be
2 subject to the jurisdiction of the Legislative Ethics
3 Commission, not the Executive Ethics Commission, and all
4 requests under the Freedom of Information Act shall be
5 directed to the applicable Freedom of Information officer
6 for the General Assembly. The Department shall provide
7 operational support to the Committee as necessary. The
8 Committee is dissolved on April 1, 2019.

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

16 (f) Continuation of supplemental payments. Any
17 supplemental payments authorized under Illinois Administrative
18 Code 148 effective January 1, 2014 and that continue during
19 the period of July 1, 2014 through December 31, 2014 shall
20 remain in effect as long as the assessment imposed by Section
21 5A-2 that is in effect on December 31, 2017 remains in effect.

22 (g) Notwithstanding subsections (a) through (f) of this
23 Section and notwithstanding the changes authorized under
24 Section 5-5b.1, any updates to the system shall not result in
25 any diminishment of the overall effective rates of
26 reimbursement as of the implementation date of the new system

1 (July 1, 2014). These updates shall not preclude variations in
2 any individual component of the system or hospital rate
3 variations. Nothing in this Section shall prohibit the
4 Department from increasing the rates of reimbursement or
5 developing payments to ensure access to hospital services.
6 Nothing in this Section shall be construed to guarantee a
7 minimum amount of spending in the aggregate or per hospital as
8 spending may be impacted by factors, including, but not
9 limited to, the number of individuals in the medical
10 assistance program and the severity of illness of the
11 individuals.

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

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

1 Related Grouping (DRG) Prospective Payment System (PPS)), and
2 4977 (Hospital Reimbursement Changes), and published in the
3 Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499
4 (Specialized Health Care Delivery Systems) and 6505 (Hospital
5 Services).

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

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

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

19 (Source: P.A. 101-81, eff. 7-12-19; 101-650, eff. 7-7-20;
20 101-655, eff. 3-12-21; 102-682, eff. 12-10-21; 102-1037, eff.
21 6-2-22; revised 8-22-22.)

22 (305 ILCS 5/14-12.5 new)

23 Sec. 14-12.5. Hospital rate updates.

24 (a) Notwithstanding any other provision of this Code, the
25 hospital rates of reimbursement authorized under Sections

1 5-5.05, 14-12, and 14-13 of this Code shall be adjusted in
2 accordance with the provisions of this Section.

3 (b) Notwithstanding any other provision of this Code,
4 effective for dates of service on and after January 1, 2024,
5 subject to federal approval, hospital reimbursement rates
6 shall be revised as follows:

7 (1) For inpatient general acute care services, the
8 statewide-standardized amount and the per diem rates for
9 hospitals exempt from the APR-DRG reimbursement system, in
10 effect January 1, 2023, shall be increased by 10%.

11 (2) For inpatient psychiatric services:

12 (A) For safety-net hospitals, the hospital
13 specific per diem rate in effect January 1, 2023 and
14 the minimum per diem rate of \$630, authorized in
15 subsection (b-5) of Section 5-5.05 of this Code, shall
16 be increased by 10%.

17 (B) For all general acute care hospitals that are
18 not safety-net hospitals, the inpatient psychiatric
19 care per diem rates in effect January 1, 2023 shall be
20 increased by 10%, except that all rates shall be at
21 least 90% of the minimum inpatient psychiatric care
22 per diem rate for safety-net hospitals as authorized
23 in subsection (b-5) of Section 5-5.05 of this Code
24 including the adjustments authorized in this Section.
25 The statewide default per diem rate for a hospital
26 opening a new psychiatric distinct part unit, shall be

1 set at 90% of the minimum inpatient psychiatric care
2 per diem rate for safety-net hospitals as authorized
3 in subsection (b-5) of Section 5-5.05 of this Code,
4 including the adjustment authorized in this Section.

5 (C) For all psychiatric specialty hospitals, the
6 per diem rates in effect January 1, 2023, shall be
7 increased by 10%, except that all rates shall be at
8 least 90% of the minimum inpatient per diem rate for
9 safety-net hospitals as authorized in subsection (b-5)
10 of Section 5-5.05 of this Code, including the
11 adjustments authorized in this Section. The statewide
12 default per diem rate for a new psychiatric specialty
13 hospital shall be set at 90% of the minimum inpatient
14 psychiatric care per diem rate for safety-net
15 hospitals as authorized in subsection (b-5) of Section
16 5-5.05 of this Code, including the adjustment
17 authorized in this Section.

18 (3) For inpatient rehabilitative services, all
19 hospital specific per diem rates in effect January 1,
20 2023, shall be increased by 10%. The statewide default
21 inpatient rehabilitative services per diem rates, for
22 general acute care hospitals and for rehabilitation
23 specialty hospitals respectively, shall be increased by
24 10%.

25 (4) The statewide-standardized amount for outpatient
26 general acute care services in effect January 1, 2023,

1 shall be increased by 10%.

2 (5) The statewide-standardized amount for outpatient
3 psychiatric care services in effect January 1, 2023, shall
4 be increased by 10%.

5 (6) The statewide-standardized amount for outpatient
6 rehabilitative care services in effect January 1, 2023,
7 shall be increased by 10%.

8 (7) The per diem rate in effect January 1, 2023, as
9 authorized in subsection (a) of Section 14-13 of this
10 Article shall be increased by 10%.

11 (8) Beginning on and after January 1, 2024, subject to
12 federal approval, in addition to the statewide
13 standardized amount, an add-on payment of \$210 shall be
14 paid for each inpatient General Acute and Psychiatric day
15 of care, excluding Medicare-Medicaid dual eligible
16 crossover days, for all safety-net hospitals defined in
17 Section 5-5e.1 of this Code.

18 (A) For Psychiatric days of care, the Department
19 may implement payment of this add-on by increasing the
20 hospital specific psychiatric per diem rate, adjusted
21 in accordance with subparagraph (A) of paragraph (2)
22 of subsection (b) by \$210, or by a separate add-on
23 payment.

24 (B) If the add-on adjustment is added to the
25 hospital specific psychiatric per diem rate to
26 operationalize payment, the Department shall provide a

1 rate sheet to each safety-net hospital, which
2 identifies the hospital psychiatric per diem rate
3 before and after the adjustment.

4 (C) The add-on adjustment shall not be considered
5 when setting the 90% minimum rate identified in
6 paragraph (2) of subsection (b).

7 (c) The Department shall take all actions necessary to
8 ensure the changes authorized in this amendatory Act of the
9 103rd General Assembly are in effect for dates of service on
10 and after January 1, 2024, including publishing all
11 appropriate public notices, applying for federal approval of
12 amendments to the Illinois Title XIX State Plan, and adopting
13 administrative rules if necessary.

14 (d) The Department of Healthcare and Family Services may
15 adopt rules necessary to implement the changes made by this
16 amendatory Act of the 103rd General Assembly through the use
17 of emergency rulemaking in accordance with Section 5-45 of the
18 Illinois Administrative Procedure Act. The 24-month limitation
19 on the adoption of emergency rules does not apply to rules
20 adopted under this Section. The General Assembly finds that
21 the adoption of rules to implement the changes made by this
22 amendatory Act of the 103rd General Assembly is deemed an
23 emergency and necessary for the public interest, safety, and
24 welfare.

25 (e) The Department shall ensure that all necessary
26 adjustments to the managed care organization capitation base

1 rates necessitated by the adjustments in this Section are
2 completed, published, and applied in accordance with Section
3 5-30.8 of this Code 90 days prior to the implementation date of
4 the changes required under this amendatory Act of the 103rd
5 General Assembly.

6 (f) The Department shall publish updated rate sheets for
7 all hospitals 30 days prior to the effective date of the rate
8 increase, or within 30 days after federal approval by the
9 Centers for Medicare and Medicaid Services, whichever is
10 later.

11 (305 ILCS 5/14-12.7 new)

12 Sec. 14-12.7. Public critical access hospital
13 stabilization program.

14 (a) In order to address the growing challenges of
15 providing stable access to healthcare in rural Illinois, by
16 October 1, 2023, the Department shall adopt rules to implement
17 for dates of service on and after January 1, 2024, subject to
18 federal approval, a program to provide at least \$3,500,000 in
19 annual financial support to public, critical access hospitals
20 in Illinois, for the delivery of perinatal and obstetrical or
21 gynecological services, behavioral healthcare services,
22 including substance use disorder services, telehealth
23 services, and other specialty services.

24 (b) The funding allocation methodology shall provide added
25 consideration to the services provided by qualifying hospitals

1 designated by the Department of Public Health as a perinatal
2 center.

3 (c) Public critical access hospitals qualifying under this
4 Section shall not be eligible for payment under subsection (o)
5 of Section 5A-12.7 of this Code.

6 (d) As used in this Section, "public critical access
7 hospital" means a hospital designated by the Department of
8 Public Health as a critical access hospital and that is owned
9 or operated by an Illinois Government body or municipality.

10 ARTICLE 15.

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

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

14 Sec. 5-5. Medical services. The Illinois Department, by
15 rule, shall determine the quantity and quality of and the rate
16 of reimbursement for the medical assistance for which payment
17 will be authorized, and the medical services to be provided,
18 which may include all or part of the following: (1) inpatient
19 hospital services; (2) outpatient hospital services; (3) other
20 laboratory and X-ray services; (4) skilled nursing home
21 services; (5) physicians' services whether furnished in the
22 office, the patient's home, a hospital, a skilled nursing
23 home, or elsewhere; (6) medical care, or any other type of

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

1 in Section 1a of the Sexual Assault Survivors Emergency
2 Treatment Act, for injuries sustained as a result of the
3 sexual assault, including examinations and laboratory tests to
4 discover evidence which may be used in criminal proceedings
5 arising from the sexual assault; (16) the diagnosis and
6 treatment of sickle cell anemia; (16.5) services performed by
7 a chiropractic physician licensed under the Medical Practice
8 Act of 1987 and acting within the scope of his or her license,
9 including, but not limited to, chiropractic manipulative
10 treatment; and (17) any other medical care, and any other type
11 of remedial care recognized under the laws of this State. The
12 term "any other type of remedial care" shall include nursing
13 care and nursing home service for persons who rely on
14 treatment by spiritual means alone through prayer for healing.

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

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

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

24 Notwithstanding any other provision of this Code, the
25 Illinois Department may not require, as a condition of payment
26 for any laboratory test authorized under this Article, that a

1 physician's handwritten signature appear on the laboratory
2 test order form. The Illinois Department may, however, impose
3 other appropriate requirements regarding laboratory test order
4 documentation.

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

23 On and after July 1, 2012, the Department of Healthcare
24 and Family Services may provide the following services to
25 persons eligible for assistance under this Article who are
26 participating in education, training or employment programs

1 operated by the Department of Human Services as successor to
2 the Department of Public Aid:

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

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

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

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

1 provided to persons under the age of 18 under the medical
2 assistance program.

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

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

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

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

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

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

1 medical assistance under this Article, as follows:

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

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

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

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

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

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

24 The Department shall not impose a deductible, coinsurance,
25 copayment, or any other cost-sharing requirement on the
26 coverage provided under this paragraph; except that this

1 sentence does not apply to coverage of diagnostic mammograms
2 to the extent such coverage would disqualify a high-deductible
3 health plan from eligibility for a health savings account
4 pursuant to Section 223 of the Internal Revenue Code (26
5 U.S.C. 223).

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

10 For purposes of this Section:

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

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

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

25 "Breast tomosynthesis" means a radiologic procedure that
26 involves the acquisition of projection images over the

1 stationary breast to produce cross-sectional digital
2 three-dimensional images of the breast.

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

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

24 On and after January 1, 2012, providers participating in a
25 quality improvement program approved by the Department shall
26 be reimbursed for screening and diagnostic mammography at the

1 same rate as the Medicare program's rates, including the
2 increased reimbursement for digital mammography and, after
3 January 1, 2023 (the effective date of Public Act 102-1018)
4 ~~this amendatory Act of the 102nd General Assembly~~, breast
5 tomosynthesis.

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

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

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

22 Subject to federal approval, the Department shall
23 establish a rate methodology for mammography at federally
24 qualified health centers and other encounter-rate clinics.
25 These clinics or centers may also collaborate with other
26 hospital-based mammography facilities. By January 1, 2016, the

1 Department shall report to the General Assembly on the status
2 of the provision set forth in this paragraph.

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

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

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

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

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

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

22 On or after July 1, 2022, individuals who are otherwise
23 eligible for medical assistance under this Article shall
24 receive coverage for perinatal depression screenings for the
25 12-month period beginning on the last day of their pregnancy.
26 Medical assistance coverage under this paragraph shall be

1 conditioned on the use of a screening instrument approved by
2 the Department.

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

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

22 The Illinois Department, in cooperation with the
23 Departments of Human Services (as successor to the Department
24 of Alcoholism and Substance Abuse) and Public Health, through
25 a public awareness campaign, may provide information
26 concerning treatment for alcoholism and drug abuse and

1 addiction, prenatal health care, and other pertinent programs
2 directed at reducing the number of drug-affected infants born
3 to recipients of medical assistance.

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

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

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

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

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

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

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

23 Medical providers shall be required to meet certain
24 qualifications to participate in Partnerships to ensure the
25 delivery of high quality medical services. These
26 qualifications shall be determined by rule of the Illinois

1 Department and may be higher than qualifications for
2 participation in the medical assistance program. Partnership
3 sponsors may prescribe reasonable additional qualifications
4 for participation by medical providers, only with the prior
5 written approval of the Illinois Department.

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

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

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

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

1 for all prosthetic devices and any other items recognized as
2 medical equipment and supplies reimbursable under this Article
3 and shall update such list on a quarterly basis, except that
4 the acquisition costs of all prescription drugs shall be
5 updated no less frequently than every 30 days as required by
6 Section 5-5.12.

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

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

1 operational or structural changes to its information
2 technology platforms are implemented.

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

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

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

1 process. However, a disenrolled vendor may reapply without
2 penalty.

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

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

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

1 the conditional enrollment period.

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

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

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

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

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

25 For claims for services rendered during a period for which
26 a recipient received retroactive eligibility, claims must be

1 filed within 180 days after the Department determines the
2 applicant is eligible. For claims for which the Illinois
3 Department is not the primary payer, claims must be submitted
4 to the Illinois Department within 180 days after the final
5 adjudication by the primary payer.

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

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

25 To the extent consistent with applicable information and
26 privacy, security, and disclosure laws, State and federal

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

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

1 Revenue; the Department of Public Health; the Department of
2 Human Services; and the Department of Financial and
3 Professional Regulation.

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

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

1 the recipient's needs, and the requirements and costs for
2 maintaining such equipment. Subject to prior approval, such
3 rules shall enable a recipient to temporarily acquire and use
4 alternative or substitute devices or equipment pending repairs
5 or replacements of any device or equipment previously
6 authorized for such recipient by the Department.
7 Notwithstanding any provision of Section 5-5f to the contrary,
8 the Department may, by rule, exempt certain replacement
9 wheelchair parts from prior approval and, for wheelchairs,
10 wheelchair parts, wheelchair accessories, and related seating
11 and positioning items, determine the wholesale price by
12 methods other than actual acquisition costs.

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

21 In order to promote environmental responsibility, meet the
22 needs of recipients and enrollees, and achieve significant
23 cost savings, the Department, or a managed care organization
24 under contract with the Department, may provide recipients or
25 managed care enrollees who have a prescription or Certificate
26 of Medical Necessity access to refurbished durable medical

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

24 The Department shall execute, relative to the nursing home
25 prescreening project, written inter-agency agreements with the
26 Department of Human Services and the Department on Aging, to

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

1 community-based services in circumstances where federal
2 approval has been granted.

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

10 The Illinois Department shall report annually to the
11 General Assembly, no later than the second Friday in April of
12 1979 and each year thereafter, in regard to:

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

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

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

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

21 The period covered by each report shall be the 3 years
22 ending on the June 30 prior to the report. The report shall
23 include suggested legislation for consideration by the General
24 Assembly. The requirement for reporting to the General
25 Assembly shall be satisfied by filing copies of the report as
26 required by Section 3.1 of the General Assembly Organization

1 Act, and filing such additional copies with the State
2 Government Report Distribution Center for the General Assembly
3 as is required under paragraph (t) of Section 7 of the State
4 Library Act.

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

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

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

1 emergency renal dialysis services covered by the Department.
2 Providers under this Section shall be prior approved and
3 certified by the Department to perform kidney transplantation
4 and the services under this Section shall be limited to
5 services associated with kidney transplantation.

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

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

1 to, naloxone hydrochloride or any other similarly acting drug
2 approved by the U.S. Food and Drug Administration. The
3 Department shall not impose a copayment on the coverage
4 provided for naloxone hydrochloride under the medical
5 assistance program.

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

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

26 Within 90 days after October 8, 2021 (the effective date

1 of Public Act 102-665), the Department shall seek federal
2 approval of a State Plan amendment to expand coverage for
3 family planning services that includes presumptive eligibility
4 to individuals whose income is at or below 208% of the federal
5 poverty level. Coverage under this Section shall be effective
6 beginning no later than December 1, 2022.

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

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

23 Notwithstanding any other provision of this Code, within
24 12 months after June 2, 2022 (the effective date of Public Act
25 102-1037) ~~this amendatory Act of the 102nd General Assembly~~
26 and subject to federal approval, acupuncture services

1 performed by an acupuncturist licensed under the Acupuncture
2 Practice Act who is acting within the scope of his or her
3 license shall be covered under the medical assistance program.
4 The Department shall apply for any federal waiver or State
5 Plan amendment, if required, to implement this paragraph. The
6 Department may adopt any rules, including standards and
7 criteria, necessary to implement this paragraph.

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

16 (Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20;
17 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article
18 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section
19 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22;
20 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff.
21 1-1-22; 102-665, eff. 10-8-21; 102-813, eff. 5-13-22;
22 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22; 102-1038 eff.
23 1-1-23; revised 2-5-23.)

1 Section 20-5. The Illinois Public Aid Code is amended by
2 changing Section 5-5.01a as follows:

3 (305 ILCS 5/5-5.01a)

4 Sec. 5-5.01a. Supportive living facilities program.

5 (a) The Department shall establish and provide oversight
6 for a program of supportive living facilities that seek to
7 promote resident independence, dignity, respect, and
8 well-being in the most cost-effective manner.

9 A supportive living facility is (i) a free-standing
10 facility or (ii) a distinct physical and operational entity
11 within a mixed-use building that meets the criteria
12 established in subsection (d). A supportive living facility
13 integrates housing with health, personal care, and supportive
14 services and is a designated setting that offers residents
15 their own separate, private, and distinct living units.

16 Sites for the operation of the program shall be selected
17 by the Department based upon criteria that may include the
18 need for services in a geographic area, the availability of
19 funding, and the site's ability to meet the standards.

20 (b) Beginning July 1, 2014, subject to federal approval,
21 the Medicaid rates for supportive living facilities shall be
22 equal to the supportive living facility Medicaid rate
23 effective on June 30, 2014 increased by 8.85%. Once the
24 assessment imposed at Article V-G of this Code is determined
25 to be a permissible tax under Title XIX of the Social Security

1 Act, the Department shall increase the Medicaid rates for
2 supportive living facilities effective on July 1, 2014 by
3 9.09%. The Department shall apply this increase retroactively
4 to coincide with the imposition of the assessment in Article
5 V-G of this Code in accordance with the approval for federal
6 financial participation by the Centers for Medicare and
7 Medicaid Services.

8 The Medicaid rates for supportive living facilities
9 effective on July 1, 2017 must be equal to the rates in effect
10 for supportive living facilities on June 30, 2017 increased by
11 2.8%.

12 The Medicaid rates for supportive living facilities
13 effective on July 1, 2018 must be equal to the rates in effect
14 for supportive living facilities on June 30, 2018.

15 Subject to federal approval, the Medicaid rates for
16 supportive living services on and after July 1, 2019 must be at
17 least 54.3% of the average total nursing facility services per
18 diem for the geographic areas defined by the Department while
19 maintaining the rate differential for dementia care and must
20 be updated whenever the total nursing facility service per
21 diems are updated. Beginning July 1, 2022, upon the
22 implementation of the Patient Driven Payment Model, Medicaid
23 rates for supportive living services must be at least 54.3% of
24 the average total nursing services per diem rate for the
25 geographic areas. For purposes of this provision, the average
26 total nursing services per diem rate shall include all add-ons

1 for nursing facilities for the geographic area provided for in
2 Section 5-5.2. The rate differential for dementia care must be
3 maintained in these rates and the rates shall be updated
4 whenever nursing facility per diem rates are updated.

5 Effective upon federal approval, the dementia care rate
6 for supportive living services must be no less than the
7 non-dementia care supportive living services rate multiplied
8 by 1.5.

9 (c) The Department may adopt rules to implement this
10 Section. Rules that establish or modify the services,
11 standards, and conditions for participation in the program
12 shall be adopted by the Department in consultation with the
13 Department on Aging, the Department of Rehabilitation
14 Services, and the Department of Mental Health and
15 Developmental Disabilities (or their successor agencies).

16 (d) Subject to federal approval by the Centers for
17 Medicare and Medicaid Services, the Department shall accept
18 for consideration of certification under the program any
19 application for a site or building where distinct parts of the
20 site or building are designated for purposes other than the
21 provision of supportive living services, but only if:

22 (1) those distinct parts of the site or building are
23 not designated for the purpose of providing assisted
24 living services as required under the Assisted Living and
25 Shared Housing Act;

26 (2) those distinct parts of the site or building are

1 completely separate from the part of the building used for
2 the provision of supportive living program services,
3 including separate entrances;

4 (3) those distinct parts of the site or building do
5 not share any common spaces with the part of the building
6 used for the provision of supportive living program
7 services; and

8 (4) those distinct parts of the site or building do
9 not share staffing with the part of the building used for
10 the provision of supportive living program services.

11 (e) Facilities or distinct parts of facilities which are
12 selected as supportive living facilities and are in good
13 standing with the Department's rules are exempt from the
14 provisions of the Nursing Home Care Act and the Illinois
15 Health Facilities Planning Act.

16 (f) Section 9817 of the American Rescue Plan Act of 2021
17 (Public Law 117-2) authorizes a 10% enhanced federal medical
18 assistance percentage for supportive living services for a
19 12-month period from April 1, 2021 through March 31, 2022.
20 Subject to federal approval, including the approval of any
21 necessary waiver amendments or other federally required
22 documents or assurances, for a 12-month period the Department
23 must pay a supplemental \$26 per diem rate to all supportive
24 living facilities with the additional federal financial
25 participation funds that result from the enhanced federal
26 medical assistance percentage from April 1, 2021 through March

1 31, 2022. The Department may issue parameters around how the
2 supplemental payment should be spent, including quality
3 improvement activities. The Department may alter the form,
4 methods, or timeframes concerning the supplemental per diem
5 rate to comply with any subsequent changes to federal law,
6 changes made by guidance issued by the federal Centers for
7 Medicare and Medicaid Services, or other changes necessary to
8 receive the enhanced federal medical assistance percentage.

9 (Source: P.A. 101-10, eff. 6-5-19; 102-43, eff. 7-6-21;
10 102-699, eff. 4-19-22.)

11 ARTICLE 25.

12 Section 25-5. The Illinois Public Aid Code is amended by
13 adding Section 12-4.57 as follows:

14 (305 ILCS 5/12-4.57 new)

15 Sec. 12-4.57. Prospective Payment System rates; increase
16 for federally qualified health centers. Subject to federal
17 approval, the Department of Healthcare and Family Services
18 shall increase the Prospective Payment System rates for
19 federally qualified health centers to a level calculated to
20 spend an additional \$50,000,000 in the first year of
21 application using an alternative payment method acceptable to
22 the Centers for Medicare and Medicaid Services and a trade
23 association representing a majority of federally qualified

1 health centers operating in Illinois, including a rate
2 increase that is an equal percentage increase to the rates
3 paid to each federally qualified health center.

4 ARTICLE 30.

5 Section 30-5. The Specialized Mental Health Rehabilitation
6 Act of 2013 is amended by changing Section 5-107 as follows:

7 (210 ILCS 49/5-107)

8 Sec. 5-107. Quality of life enhancement. Beginning on July
9 1, 2019, for improving the quality of life and the quality of
10 care, an additional payment shall be awarded to a facility for
11 their single occupancy rooms. This payment shall be in
12 addition to the rate for recovery and rehabilitation. The
13 additional rate for single room occupancy shall be no less
14 than \$10 per day, per single room occupancy. The Department of
15 Healthcare and Family Services shall adjust payment to
16 Medicaid managed care entities to cover these costs. Beginning
17 July 1, 2022, for improving the quality of life and the quality
18 of care, a payment of no less than \$5 per day, per single room
19 occupancy shall be added to the existing \$10 additional per
20 day, per single room occupancy rate for a total of at least \$15
21 per day, per single room occupancy. For improving the quality
22 of life and the quality of care, on January 1, 2024, a payment
23 of no less than \$10.50 per day, per single room occupancy shall

1 be added to the existing \$15 additional per day, per single
2 room occupancy rate for a total of at least \$25.50 per day, per
3 single room occupancy. Beginning July 1, 2022, for improving
4 the quality of life and the quality of care, an additional
5 payment shall be awarded to a facility for its dual-occupancy
6 rooms. This payment shall be in addition to the rate for
7 recovery and rehabilitation. The additional rate for
8 dual-occupancy rooms shall be no less than \$10 per day, per
9 Medicaid-occupied bed, in each dual-occupancy room. Beginning
10 January 1, 2024, for improving the quality of life and the
11 quality of care, a payment of no less than \$4.50 per day, per
12 dual-occupancy room shall be added to the existing \$10
13 additional per day, per dual-occupancy room rate for a total
14 of at least \$14.50, per Medicaid-occupied bed, in each
15 dual-occupancy room. The Department of Healthcare and Family
16 Services shall adjust payment to Medicaid managed care
17 entities to cover these costs. As used in this Section,
18 "dual-occupancy room" means a room that contains 2 resident
19 beds.

20 (Source: P.A. 101-10, eff. 6-5-19; 102-699, eff. 4-19-22.)

21 ARTICLE 35.

22 Section 35-5. The Illinois Public Aid Code is amended by
23 changing Section 5-2b as follows:

1 (305 ILCS 5/5-2b)

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

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

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

1 in effect for nursing services on December 31, 2023.

2 (Source: P.A. 100-990, eff. 1-1-19.)

3 ARTICLE 40.

4 Section 40-5. The Illinois Public Aid Code is amended by
5 changing Section 5-5.2 as follows:

6 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

7 Sec. 5-5.2. Payment.

8 (a) All nursing facilities that are grouped pursuant to
9 Section 5-5.1 of this Act shall receive the same rate of
10 payment for similar services.

11 (b) It shall be a matter of State policy that the Illinois
12 Department shall utilize a uniform billing cycle throughout
13 the State for the long-term care providers.

14 (c) (Blank).

15 (c-1) Notwithstanding any other provisions of this Code,
16 the methodologies for reimbursement of nursing services as
17 provided under this Article shall no longer be applicable for
18 bills payable for nursing services rendered on or after a new
19 reimbursement system based on the Patient Driven Payment Model
20 (PDPM) has been fully operationalized, which shall take effect
21 for services provided on or after the implementation of the
22 PDPM reimbursement system begins. For the purposes of this
23 amendatory Act of the 102nd General Assembly, the

1 implementation date of the PDPM reimbursement system and all
2 related provisions shall be July 1, 2022 if the following
3 conditions are met: (i) the Centers for Medicare and Medicaid
4 Services has approved corresponding changes in the
5 reimbursement system and bed assessment; and (ii) the
6 Department has filed rules to implement these changes no later
7 than June 1, 2022. Failure of the Department to file rules to
8 implement the changes provided in this amendatory Act of the
9 102nd General Assembly no later than June 1, 2022 shall result
10 in the implementation date being delayed to October 1, 2022.

11 (d) The new nursing services reimbursement methodology
12 utilizing the Patient Driven Payment Model, which shall be
13 referred to as the PDPM reimbursement system, taking effect
14 July 1, 2022, upon federal approval by the Centers for
15 Medicare and Medicaid Services, shall be based on the
16 following:

17 (1) The methodology shall be resident-centered,
18 facility-specific, cost-based, and based on guidance from
19 the Centers for Medicare and Medicaid Services.

20 (2) Costs shall be annually rebased and case mix index
21 quarterly updated. The nursing services methodology will
22 be assigned to the Medicaid enrolled residents on record
23 as of 30 days prior to the beginning of the rate period in
24 the Department's Medicaid Management Information System
25 (MMIS) as present on the last day of the second quarter
26 preceding the rate period based upon the Assessment

1 Reference Date of the Minimum Data Set (MDS).

2 (3) Regional wage adjustors based on the Health
3 Service Areas (HSA) groupings and adjusters in effect on
4 April 30, 2012 shall be included, except no adjuster shall
5 be lower than 1.06.

6 (4) PDPM nursing case mix indices in effect on March
7 1, 2022 shall be assigned to each resident class at no less
8 than 0.7858 of the Centers for Medicare and Medicaid
9 Services PDPM unadjusted case mix values, in effect on
10 March 1, 2022.

11 (5) The pool of funds available for distribution by
12 case mix and the base facility rate shall be determined
13 using the formula contained in subsection (d-1).

14 (6) The Department shall establish a variable per diem
15 staffing add-on in accordance with the most recent
16 available federal staffing report, currently the Payroll
17 Based Journal, for the same period of time, and if
18 applicable adjusted for acuity using the same quarter's
19 MDS. The Department shall rely on Payroll Based Journals
20 provided to the Department of Public Health to make a
21 determination of non-submission. If the Department is
22 notified by a facility of missing or inaccurate Payroll
23 Based Journal data or an incorrect calculation of
24 staffing, the Department must make a correction as soon as
25 the error is verified for the applicable quarter.

26 Facilities with at least 70% of the staffing indicated

1 by the STRIVE study shall be paid a per diem add-on of \$9,
2 increasing by equivalent steps for each whole percentage
3 point until the facilities reach a per diem of \$14.88.
4 Facilities with at least 80% of the staffing indicated by
5 the STRIVE study shall be paid a per diem add-on of \$14.88,
6 increasing by equivalent steps for each whole percentage
7 point until the facilities reach a per diem add-on of
8 \$23.80. Facilities with at least 92% of the staffing
9 indicated by the STRIVE study shall be paid a per diem
10 add-on of \$23.80, increasing by equivalent steps for each
11 whole percentage point until the facilities reach a per
12 diem add-on of \$29.75. Facilities with at least 100% of
13 the staffing indicated by the STRIVE study shall be paid a
14 per diem add-on of \$29.75, increasing by equivalent steps
15 for each whole percentage point until the facilities reach
16 a per diem add-on of \$35.70. Facilities with at least 110%
17 of the staffing indicated by the STRIVE study shall be
18 paid a per diem add-on of \$35.70, increasing by equivalent
19 steps for each whole percentage point until the facilities
20 reach a per diem add-on of \$38.68. Facilities with at
21 least 125% or higher of the staffing indicated by the
22 STRIVE study shall be paid a per diem add-on of \$38.68.
23 Beginning April 1, 2023, no nursing facility's variable
24 staffing per diem add-on shall be reduced by more than 5%
25 in 2 consecutive quarters. For the quarters beginning July
26 1, 2022 and October 1, 2022, no facility's variable per

1 diem staffing add-on shall be calculated at a rate lower
2 than 85% of the staffing indicated by the STRIVE study. No
3 facility below 70% of the staffing indicated by the STRIVE
4 study shall receive a variable per diem staffing add-on
5 after December 31, 2022.

6 (7) For dates of services beginning July 1, 2022, the
7 PDPM nursing component per diem for each nursing facility
8 shall be the product of the facility's (i) statewide PDPM
9 nursing base per diem rate, \$92.25, adjusted for the
10 facility average PDPM case mix index calculated quarterly
11 and (ii) the regional wage adjuster, and then add the
12 Medicaid access adjustment as defined in (e-3) of this
13 Section. Transition rates for services provided between
14 July 1, 2022 and October 1, 2023 shall be the greater of
15 the PDPM nursing component per diem or:

16 (A) for the quarter beginning July 1, 2022, the
17 RUG-IV nursing component per diem;

18 (B) for the quarter beginning October 1, 2022, the
19 sum of the RUG-IV nursing component per diem
20 multiplied by 0.80 and the PDPM nursing component per
21 diem multiplied by 0.20;

22 (C) for the quarter beginning January 1, 2023, the
23 sum of the RUG-IV nursing component per diem
24 multiplied by 0.60 and the PDPM nursing component per
25 diem multiplied by 0.40;

26 (D) for the quarter beginning April 1, 2023, the

1 sum of the RUG-IV nursing component per diem
2 multiplied by 0.40 and the PDPM nursing component per
3 diem multiplied by 0.60;

4 (E) for the quarter beginning July 1, 2023, the
5 sum of the RUG-IV nursing component per diem
6 multiplied by 0.20 and the PDPM nursing component per
7 diem multiplied by 0.80; or

8 (F) for the quarter beginning October 1, 2023 and
9 each subsequent quarter, the transition rate shall end
10 and a nursing facility shall be paid 100% of the PDPM
11 nursing component per diem.

12 (d-1) Calculation of base year Statewide RUG-IV nursing
13 base per diem rate.

14 (1) Base rate spending pool shall be:

15 (A) The base year resident days which are
16 calculated by multiplying the number of Medicaid
17 residents in each nursing home as indicated in the MDS
18 data defined in paragraph (4) by 365.

19 (B) Each facility's nursing component per diem in
20 effect on July 1, 2012 shall be multiplied by
21 subsection (A).

22 (C) Thirteen million is added to the product of
23 subparagraph (A) and subparagraph (B) to adjust for
24 the exclusion of nursing homes defined in paragraph
25 (5).

26 (2) For each nursing home with Medicaid residents as

1 indicated by the MDS data defined in paragraph (4),
2 weighted days adjusted for case mix and regional wage
3 adjustment shall be calculated. For each home this
4 calculation is the product of:

5 (A) Base year resident days as calculated in
6 subparagraph (A) of paragraph (1).

7 (B) The nursing home's regional wage adjustor
8 based on the Health Service Areas (HSA) groupings and
9 adjustors in effect on April 30, 2012.

10 (C) Facility weighted case mix which is the number
11 of Medicaid residents as indicated by the MDS data
12 defined in paragraph (4) multiplied by the associated
13 case weight for the RUG-IV 48 grouper model using
14 standard RUG-IV procedures for index maximization.

15 (D) The sum of the products calculated for each
16 nursing home in subparagraphs (A) through (C) above
17 shall be the base year case mix, rate adjusted
18 weighted days.

19 (3) The Statewide RUG-IV nursing base per diem rate:

20 (A) on January 1, 2014 shall be the quotient of the
21 paragraph (1) divided by the sum calculated under
22 subparagraph (D) of paragraph (2);

23 (B) on and after July 1, 2014 and until July 1,
24 2022, shall be the amount calculated under
25 subparagraph (A) of this paragraph (3) plus \$1.76; and

26 (C) beginning July 1, 2022 and thereafter, \$7

1 shall be added to the amount calculated under
2 subparagraph (B) of this paragraph (3) of this
3 Section.

4 (4) Minimum Data Set (MDS) comprehensive assessments
5 for Medicaid residents on the last day of the quarter used
6 to establish the base rate.

7 (5) Nursing facilities designated as of July 1, 2012
8 by the Department as "Institutions for Mental Disease"
9 shall be excluded from all calculations under this
10 subsection. The data from these facilities shall not be
11 used in the computations described in paragraphs (1)
12 through (4) above to establish the base rate.

13 (e) Beginning July 1, 2014, the Department shall allocate
14 funding in the amount up to \$10,000,000 for per diem add-ons to
15 the RUGS methodology for dates of service on and after July 1,
16 2014:

17 (1) \$0.63 for each resident who scores in I4200
18 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

19 (2) \$2.67 for each resident who scores either a "1" or
20 "2" in any items S1200A through S1200I and also scores in
21 RUG groups PA1, PA2, BA1, or BA2.

22 (e-1) (Blank).

23 (e-2) For dates of services beginning January 1, 2014 and
24 ending September 30, 2023, the RUG-IV nursing component per
25 diem for a nursing home shall be the product of the statewide
26 RUG-IV nursing base per diem rate, the facility average case

1 mix index, and the regional wage adjustor. For dates of
2 service beginning July 1, 2022 and ending September 30, 2023,
3 the Medicaid access adjustment described in subsection (e-3)
4 shall be added to the product.

5 (e-3) A Medicaid Access Adjustment of \$4 adjusted for the
6 facility average PDPM case mix index calculated quarterly
7 shall be added to the statewide PDPM nursing per diem for all
8 facilities with annual Medicaid bed days of at least 70% of all
9 occupied bed days adjusted quarterly. For each new calendar
10 year and for the 6-month period beginning July 1, 2022, the
11 percentage of a facility's occupied bed days comprised of
12 Medicaid bed days shall be determined by the Department
13 quarterly. For dates of service beginning January 1, 2023, the
14 Medicaid Access Adjustment shall be increased to \$4.75. This
15 subsection shall be inoperative on and after January 1, 2028.

16 (f) (Blank).

17 (g) Notwithstanding any other provision of this Code, on
18 and after July 1, 2012, for facilities not designated by the
19 Department of Healthcare and Family Services as "Institutions
20 for Mental Disease", rates effective May 1, 2011 shall be
21 adjusted as follows:

22 (1) (Blank);

23 (2) (Blank);

24 (3) Facility rates for the capital and support
25 components shall be reduced by 1.7%.

26 (h) Notwithstanding any other provision of this Code, on

1 and after July 1, 2012, nursing facilities designated by the
2 Department of Healthcare and Family Services as "Institutions
3 for Mental Disease" and "Institutions for Mental Disease" that
4 are facilities licensed under the Specialized Mental Health
5 Rehabilitation Act of 2013 shall have the nursing,
6 socio-developmental, capital, and support components of their
7 reimbursement rate effective May 1, 2011 reduced in total by
8 2.7%.

9 (i) On and after July 1, 2014, the reimbursement rates for
10 the support component of the nursing facility rate for
11 facilities licensed under the Nursing Home Care Act as skilled
12 or intermediate care facilities shall be the rate in effect on
13 June 30, 2014 increased by 8.17%.

14 (i-1) Subject to federal approval, the reimbursement rates
15 for the support component of the nursing facility rate for
16 facilities licensed under the Nursing Home Care Act as skilled
17 or intermediate care facilities shall be the rate in effect on
18 June 30, 2023 increased by 12%.

19 (j) Notwithstanding any other provision of law, subject to
20 federal approval, effective July 1, 2019, sufficient funds
21 shall be allocated for changes to rates for facilities
22 licensed under the Nursing Home Care Act as skilled nursing
23 facilities or intermediate care facilities for dates of
24 services on and after July 1, 2019: (i) to establish, through
25 June 30, 2022 a per diem add-on to the direct care per diem
26 rate not to exceed \$70,000,000 annually in the aggregate

1 taking into account federal matching funds for the purpose of
2 addressing the facility's unique staffing needs, adjusted
3 quarterly and distributed by a weighted formula based on
4 Medicaid bed days on the last day of the second quarter
5 preceding the quarter for which the rate is being adjusted.
6 Beginning July 1, 2022, the annual \$70,000,000 described in
7 the preceding sentence shall be dedicated to the variable per
8 diem add-on for staffing under paragraph (6) of subsection
9 (d); and (ii) in an amount not to exceed \$170,000,000 annually
10 in the aggregate taking into account federal matching funds to
11 permit the support component of the nursing facility rate to
12 be updated as follows:

13 (1) 80%, or \$136,000,000, of the funds shall be used
14 to update each facility's rate in effect on June 30, 2019
15 using the most recent cost reports on file, which have had
16 a limited review conducted by the Department of Healthcare
17 and Family Services and will not hold up enacting the rate
18 increase, with the Department of Healthcare and Family
19 Services.

20 (2) After completing the calculation in paragraph (1),
21 any facility whose rate is less than the rate in effect on
22 June 30, 2019 shall have its rate restored to the rate in
23 effect on June 30, 2019 from the 20% of the funds set
24 aside.

25 (3) The remainder of the 20%, or \$34,000,000, shall be
26 used to increase each facility's rate by an equal

1 percentage.

2 (k) During the first quarter of State Fiscal Year 2020,
3 the Department of Healthcare of Family Services must convene a
4 technical advisory group consisting of members of all trade
5 associations representing Illinois skilled nursing providers
6 to discuss changes necessary with federal implementation of
7 Medicare's Patient-Driven Payment Model. Implementation of
8 Medicare's Patient-Driven Payment Model shall, by September 1,
9 2020, end the collection of the MDS data that is necessary to
10 maintain the current RUG-IV Medicaid payment methodology. The
11 technical advisory group must consider a revised reimbursement
12 methodology that takes into account transparency,
13 accountability, actual staffing as reported under the
14 federally required Payroll Based Journal system, changes to
15 the minimum wage, adequacy in coverage of the cost of care, and
16 a quality component that rewards quality improvements.

17 (l) The Department shall establish per diem add-on
18 payments to improve the quality of care delivered by
19 facilities, including:

20 (1) Incentive payments determined by facility
21 performance on specified quality measures in an initial
22 amount of \$70,000,000. Nothing in this subsection shall be
23 construed to limit the quality of care payments in the
24 aggregate statewide to \$70,000,000, and, if quality of
25 care has improved across nursing facilities, the
26 Department shall adjust those add-on payments accordingly.

1 The quality payment methodology described in this
2 subsection must be used for at least State Fiscal Year
3 2023. Beginning with the quarter starting July 1, 2023,
4 the Department may add, remove, or change quality metrics
5 and make associated changes to the quality payment
6 methodology as outlined in subparagraph (E). Facilities
7 designated by the Centers for Medicare and Medicaid
8 Services as a special focus facility or a hospital-based
9 nursing home do not qualify for quality payments.

10 (A) Each quality pool must be distributed by
11 assigning a quality weighted score for each nursing
12 home which is calculated by multiplying the nursing
13 home's quality base period Medicaid days by the
14 nursing home's star rating weight in that period.

15 (B) Star rating weights are assigned based on the
16 nursing home's star rating for the LTS quality star
17 rating. As used in this subparagraph, "LTS quality
18 star rating" means the long-term stay quality rating
19 for each nursing facility, as assigned by the Centers
20 for Medicare and Medicaid Services under the Five-Star
21 Quality Rating System. The rating is a number ranging
22 from 0 (lowest) to 5 (highest).

23 (i) Zero-star or one-star rating has a weight
24 of 0.

25 (ii) Two-star rating has a weight of 0.75.

26 (iii) Three-star rating has a weight of 1.5.

1 (iv) Four-star rating has a weight of 2.5.

2 (v) Five-star rating has a weight of 3.5.

3 (C) Each nursing home's quality weight score is
4 divided by the sum of all quality weight scores for
5 qualifying nursing homes to determine the proportion
6 of the quality pool to be paid to the nursing home.

7 (D) The quality pool is no less than \$70,000,000
8 annually or \$17,500,000 per quarter. The Department
9 shall publish on its website the estimated payments
10 and the associated weights for each facility 45 days
11 prior to when the initial payments for the quarter are
12 to be paid. The Department shall assign each facility
13 the most recent and applicable quarter's STAR value
14 unless the facility notifies the Department within 15
15 days of an issue and the facility provides reasonable
16 evidence demonstrating its timely compliance with
17 federal data submission requirements for the quarter
18 of record. If such evidence cannot be provided to the
19 Department, the STAR rating assigned to the facility
20 shall be reduced by one from the prior quarter.

21 (E) The Department shall review quality metrics
22 used for payment of the quality pool and make
23 recommendations for any associated changes to the
24 methodology for distributing quality pool payments in
25 consultation with associations representing long-term
26 care providers, consumer advocates, organizations

1 representing workers of long-term care facilities, and
2 payors. The Department may establish, by rule, changes
3 to the methodology for distributing quality pool
4 payments.

5 (F) The Department shall disburse quality pool
6 payments from the Long-Term Care Provider Fund on a
7 monthly basis in amounts proportional to the total
8 quality pool payment determined for the quarter.

9 (G) The Department shall publish any changes in
10 the methodology for distributing quality pool payments
11 prior to the beginning of the measurement period or
12 quality base period for any metric added to the
13 distribution's methodology.

14 (2) Payments based on CNA tenure, promotion, and CNA
15 training for the purpose of increasing CNA compensation.
16 It is the intent of this subsection that payments made in
17 accordance with this paragraph be directly incorporated
18 into increased compensation for CNAs. As used in this
19 paragraph, "CNA" means a certified nursing assistant as
20 that term is described in Section 3-206 of the Nursing
21 Home Care Act, Section 3-206 of the ID/DD Community Care
22 Act, and Section 3-206 of the MC/DD Act. The Department
23 shall establish, by rule, payments to nursing facilities
24 equal to Medicaid's share of the tenure wage increments
25 specified in this paragraph for all reported CNA employee
26 hours compensated according to a posted schedule

1 consisting of increments at least as large as those
2 specified in this paragraph. The increments are as
3 follows: an additional \$1.50 per hour for CNAs with at
4 least one and less than 2 years' experience plus another
5 \$1 per hour for each additional year of experience up to a
6 maximum of \$6.50 for CNAs with at least 6 years of
7 experience. For purposes of this paragraph, Medicaid's
8 share shall be the ratio determined by paid Medicaid bed
9 days divided by total bed days for the applicable time
10 period used in the calculation. In addition, and additive
11 to any tenure increments paid as specified in this
12 paragraph, the Department shall establish, by rule,
13 payments supporting Medicaid's share of the
14 promotion-based wage increments for CNA employee hours
15 compensated for that promotion with at least a \$1.50
16 hourly increase. Medicaid's share shall be established as
17 it is for the tenure increments described in this
18 paragraph. Qualifying promotions shall be defined by the
19 Department in rules for an expected 10-15% subset of CNAs
20 assigned intermediate, specialized, or added roles such as
21 CNA trainers, CNA scheduling "captains", and CNA
22 specialists for resident conditions like dementia or
23 memory care or behavioral health.

24 (m) The Department shall work with nursing facility
25 industry representatives to design policies and procedures to
26 permit facilities to address the integrity of data from

1 federal reporting sites used by the Department in setting
2 facility rates.

3 (Source: P.A. 101-10, eff. 6-5-19; 101-348, eff. 8-9-19;
4 102-77, eff. 7-9-21; 102-558, eff. 8-20-21; 102-1035, eff.
5 5-31-22; 102-1118, eff. 1-18-23.)

6 ARTICLE 45.

7 Section 45-5. The Illinois Act on the Aging is amended by
8 changing Section 4.02 as follows:

9 (20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

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

21 (a) (blank);

22 (b) (blank);

23 (c) home care aide services;

- 1 (d) personal assistant services;
- 2 (e) adult day services;
- 3 (f) home-delivered meals;
- 4 (g) education in self-care;
- 5 (h) personal care services;
- 6 (i) adult day health services;
- 7 (j) habilitation services;
- 8 (k) respite care;
- 9 (k-5) community reintegration services;
- 10 (k-6) flexible senior services;
- 11 (k-7) medication management;
- 12 (k-8) emergency home response;
- 13 (l) other nonmedical social services that may enable
- 14 the person to become self-supporting; or
- 15 (m) clearinghouse for information provided by senior
- 16 citizen home owners who want to rent rooms to or share
- 17 living space with other senior citizens.

18 The Department shall establish eligibility standards for

19 such services. In determining the amount and nature of

20 services for which a person may qualify, consideration shall

21 not be given to the value of cash, property or other assets

22 held in the name of the person's spouse pursuant to a written

23 agreement dividing marital property into equal but separate

24 shares or pursuant to a transfer of the person's interest in a

25 home to his spouse, provided that the spouse's share of the

26 marital property is not made available to the person seeking

1 such services.

2 Beginning January 1, 2008, the Department shall require as
3 a condition of eligibility that all new financially eligible
4 applicants apply for and enroll in medical assistance under
5 Article V of the Illinois Public Aid Code in accordance with
6 rules promulgated by the Department.

7 The Department shall, in conjunction with the Department
8 of Public Aid (now Department of Healthcare and Family
9 Services), seek appropriate amendments under Sections 1915 and
10 1924 of the Social Security Act. The purpose of the amendments
11 shall be to extend eligibility for home and community based
12 services under Sections 1915 and 1924 of the Social Security
13 Act to persons who transfer to or for the benefit of a spouse
14 those amounts of income and resources allowed under Section
15 1924 of the Social Security Act. Subject to the approval of
16 such amendments, the Department shall extend the provisions of
17 Section 5-4 of the Illinois Public Aid Code to persons who, but
18 for the provision of home or community-based services, would
19 require the level of care provided in an institution, as is
20 provided for in federal law. Those persons no longer found to
21 be eligible for receiving noninstitutional services due to
22 changes in the eligibility criteria shall be given 45 days
23 notice prior to actual termination. Those persons receiving
24 notice of termination may contact the Department and request
25 the determination be appealed at any time during the 45 day
26 notice period. The target population identified for the

1 purposes of this Section are persons age 60 and older with an
2 identified service need. Priority shall be given to those who
3 are at imminent risk of institutionalization. The services
4 shall be provided to eligible persons age 60 and older to the
5 extent that the cost of the services together with the other
6 personal maintenance expenses of the persons are reasonably
7 related to the standards established for care in a group
8 facility appropriate to the person's condition. These
9 non-institutional services, pilot projects or experimental
10 facilities may be provided as part of or in addition to those
11 authorized by federal law or those funded and administered by
12 the Department of Human Services. The Departments of Human
13 Services, Healthcare and Family Services, Public Health,
14 Veterans' Affairs, and Commerce and Economic Opportunity and
15 other appropriate agencies of State, federal and local
16 governments shall cooperate with the Department on Aging in
17 the establishment and development of the non-institutional
18 services. The Department shall require an annual audit from
19 all personal assistant and home care aide vendors contracting
20 with the Department under this Section. The annual audit shall
21 assure that each audited vendor's procedures are in compliance
22 with Department's financial reporting guidelines requiring an
23 administrative and employee wage and benefits cost split as
24 defined in administrative rules. The audit is a public record
25 under the Freedom of Information Act. The Department shall
26 execute, relative to the nursing home prescreening project,

1 written inter-agency agreements with the Department of Human
2 Services and the Department of Healthcare and Family Services,
3 to effect the following: (1) intake procedures and common
4 eligibility criteria for those persons who are receiving
5 non-institutional services; and (2) the establishment and
6 development of non-institutional services in areas of the
7 State where they are not currently available or are
8 undeveloped. On and after July 1, 1996, all nursing home
9 prescreenings for individuals 60 years of age or older shall
10 be conducted by the Department.

11 As part of the Department on Aging's routine training of
12 case managers and case manager supervisors, the Department may
13 include information on family futures planning for persons who
14 are age 60 or older and who are caregivers of their adult
15 children with developmental disabilities. The content of the
16 training shall be at the Department's discretion.

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

1 The Department, or the Department's authorized
2 representative, may recover the amount of moneys expended for
3 services provided to or in behalf of a person under this
4 Section by a claim against the person's estate or against the
5 estate of the person's surviving spouse, but no recovery may
6 be had until after the death of the surviving spouse, if any,
7 and then only at such time when there is no surviving child who
8 is under age 21 or blind or who has a permanent and total
9 disability. This paragraph, however, shall not bar recovery,
10 at the death of the person, of moneys for services provided to
11 the person or in behalf of the person under this Section to
12 which the person was not entitled; provided that such recovery
13 shall not be enforced against any real estate while it is
14 occupied as a homestead by the surviving spouse or other
15 dependent, if no claims by other creditors have been filed
16 against the estate, or, if such claims have been filed, they
17 remain dormant for failure of prosecution or failure of the
18 claimant to compel administration of the estate for the
19 purpose of payment. This paragraph shall not bar recovery from
20 the estate of a spouse, under Sections 1915 and 1924 of the
21 Social Security Act and Section 5-4 of the Illinois Public Aid
22 Code, who precedes a person receiving services under this
23 Section in death. All moneys for services paid to or in behalf
24 of the person under this Section shall be claimed for recovery
25 from the deceased spouse's estate. "Homestead", as used in
26 this paragraph, means the dwelling house and contiguous real

1 estate occupied by a surviving spouse or relative, as defined
2 by the rules and regulations of the Department of Healthcare
3 and Family Services, regardless of the value of the property.

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

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

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

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

20 (4) ensuring that the determination of need tool is
21 accurate in determining the participants' level of need;
22 to achieve this, the Department, in conjunction with the
23 Older Adult Services Advisory Committee, shall institute a
24 study of the relationship between the Determination of
25 Need scores, level of need, service cost maximums, and the
26 development and utilization of service plans no later than

1 May 1, 2008; findings and recommendations shall be
2 presented to the Governor and the General Assembly no
3 later than January 1, 2009; recommendations shall include
4 all needed changes to the service cost maximums schedule
5 and additional covered services;

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

9 (A) bathing;

10 (B) grooming;

11 (C) toileting;

12 (D) nail care;

13 (E) transferring;

14 (F) respiratory services;

15 (G) exercise; or

16 (H) positioning;

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

23 (7) ensuring that the State may access maximum federal
24 matching funds by seeking approval for the Centers for
25 Medicare and Medicaid Services for modifications to the
26 State's home and community based services waiver and

1 additional waiver opportunities, including applying for
2 enrollment in the Balance Incentive Payment Program by May
3 1, 2013, in order to maximize federal matching funds; this
4 shall include, but not be limited to, modification that
5 reflects all changes in the Community Care Program
6 services and all increases in the services cost maximum;

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

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

19 (10) working in conjunction with Care Coordination
20 Units, the Department of Healthcare and Family Services,
21 the Department of Human Services, Community Care Program
22 providers, and other stakeholders to make improvements to
23 the Medicaid claiming processes and the Medicaid
24 enrollment procedures or requirements as needed,
25 including, but not limited to, specific policy changes or
26 rules to improve the up-front enrollment of participants

1 in the Medicaid program and specific policy changes or
2 rules to insure more prompt submission of bills to the
3 federal government to secure maximum federal matching
4 dollars as promptly as possible; the Department on Aging
5 shall have at least 3 meetings with stakeholders by
6 January 1, 2014 in order to address these improvements;

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

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

18 (13) maintaining fiscal year 2014 rates at the same
19 level established on January 1, 2013.

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

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

3 The Department shall develop procedures to enhance
4 availability of services on evenings, weekends, and on an
5 emergency basis to meet the respite needs of caregivers.
6 Procedures shall be developed to permit the utilization of
7 services in successive blocks of 24 hours up to the monthly
8 maximum established by the Department. Workers providing these
9 services shall be appropriately trained.

10 Beginning on the effective date of this amendatory Act of
11 1991, no person may perform chore/housekeeping and home care
12 aide services under a program authorized by this Section
13 unless that person has been issued a certificate of
14 pre-service to do so by his or her employing agency.
15 Information gathered to effect such certification shall
16 include (i) the person's name, (ii) the date the person was
17 hired by his or her current employer, and (iii) the training,
18 including dates and levels. Persons engaged in the program
19 authorized by this Section before the effective date of this
20 amendatory Act of 1991 shall be issued a certificate of all
21 pre- and in-service training from his or her employer upon
22 submitting the necessary information. The employing agency
23 shall be required to retain records of all staff pre- and
24 in-service training, and shall provide such records to the
25 Department upon request and upon termination of the employer's
26 contract with the Department. In addition, the employing

1 agency is responsible for the issuance of certifications of
2 in-service training completed to their employees.

3 The Department is required to develop a system to ensure
4 that persons working as home care aides and personal
5 assistants receive increases in their wages when the federal
6 minimum wage is increased by requiring vendors to certify that
7 they are meeting the federal minimum wage statute for home
8 care aides and personal assistants. An employer that cannot
9 ensure that the minimum wage increase is being given to home
10 care aides and personal assistants shall be denied any
11 increase in reimbursement costs.

12 The Community Care Program Advisory Committee is created
13 in the Department on Aging. The Director shall appoint
14 individuals to serve in the Committee, who shall serve at
15 their own expense. Members of the Committee must abide by all
16 applicable ethics laws. The Committee shall advise the
17 Department on issues related to the Department's program of
18 services to prevent unnecessary institutionalization. The
19 Committee shall meet on a bi-monthly basis and shall serve to
20 identify and advise the Department on present and potential
21 issues affecting the service delivery network, the program's
22 clients, and the Department and to recommend solution
23 strategies. Persons appointed to the Committee shall be
24 appointed on, but not limited to, their own and their agency's
25 experience with the program, geographic representation, and
26 willingness to serve. The Director shall appoint members to

1 the Committee to represent provider, advocacy, policy
2 research, and other constituencies committed to the delivery
3 of high quality home and community-based services to older
4 adults. Representatives shall be appointed to ensure
5 representation from community care providers including, but
6 not limited to, adult day service providers, homemaker
7 providers, case coordination and case management units,
8 emergency home response providers, statewide trade or labor
9 unions that represent home care aides and direct care staff,
10 area agencies on aging, adults over age 60, membership
11 organizations representing older adults, and other
12 organizational entities, providers of care, or individuals
13 with demonstrated interest and expertise in the field of home
14 and community care as determined by the Director.

15 Nominations may be presented from any agency or State
16 association with interest in the program. The Director, or his
17 or her designee, shall serve as the permanent co-chair of the
18 advisory committee. One other co-chair shall be nominated and
19 approved by the members of the committee on an annual basis.
20 Committee members' terms of appointment shall be for 4 years
21 with one-quarter of the appointees' terms expiring each year.
22 A member shall continue to serve until his or her replacement
23 is named. The Department shall fill vacancies that have a
24 remaining term of over one year, and this replacement shall
25 occur through the annual replacement of expiring terms. The
26 Director shall designate Department staff to provide technical

1 assistance and staff support to the committee. Department
2 representation shall not constitute membership of the
3 committee. All Committee papers, issues, recommendations,
4 reports, and meeting memoranda are advisory only. The
5 Director, or his or her designee, shall make a written report,
6 as requested by the Committee, regarding issues before the
7 Committee.

8 The Department on Aging and the Department of Human
9 Services shall cooperate in the development and submission of
10 an annual report on programs and services provided under this
11 Section. Such joint report shall be filed with the Governor
12 and the General Assembly on or before September 30 each year.

13 The requirement for reporting to the General Assembly
14 shall be satisfied by filing copies of the report as required
15 by Section 3.1 of the General Assembly Organization Act and
16 filing such additional copies with the State Government Report
17 Distribution Center for the General Assembly as is required
18 under paragraph (t) of Section 7 of the State Library Act.

19 Those persons previously found eligible for receiving
20 non-institutional services whose services were discontinued
21 under the Emergency Budget Act of Fiscal Year 1992, and who do
22 not meet the eligibility standards in effect on or after July
23 1, 1992, shall remain ineligible on and after July 1, 1992.
24 Those persons previously not required to cost-share and who
25 were required to cost-share effective March 1, 1992, shall
26 continue to meet cost-share requirements on and after July 1,

1 1992. Beginning July 1, 1992, all clients will be required to
2 meet eligibility, cost-share, and other requirements and will
3 have services discontinued or altered when they fail to meet
4 these requirements.

5 For the purposes of this Section, "flexible senior
6 services" refers to services that require one-time or periodic
7 expenditures including, but not limited to, respite care, home
8 modification, assistive technology, housing assistance, and
9 transportation.

10 The Department shall implement an electronic service
11 verification based on global positioning systems or other
12 cost-effective technology for the Community Care Program no
13 later than January 1, 2014.

14 The Department shall require, as a condition of
15 eligibility, enrollment in the medical assistance program
16 under Article V of the Illinois Public Aid Code (i) beginning
17 August 1, 2013, if the Auditor General has reported that the
18 Department has failed to comply with the reporting
19 requirements of Section 2-27 of the Illinois State Auditing
20 Act; or (ii) beginning June 1, 2014, if the Auditor General has
21 reported that the Department has not undertaken the required
22 actions listed in the report required by subsection (a) of
23 Section 2-27 of the Illinois State Auditing Act.

24 The Department shall delay Community Care Program services
25 until an applicant is determined eligible for medical
26 assistance under Article V of the Illinois Public Aid Code (i)

1 beginning August 1, 2013, if the Auditor General has reported
2 that the Department has failed to comply with the reporting
3 requirements of Section 2-27 of the Illinois State Auditing
4 Act; or (ii) beginning June 1, 2014, if the Auditor General has
5 reported that the Department has not undertaken the required
6 actions listed in the report required by subsection (a) of
7 Section 2-27 of the Illinois State Auditing Act.

8 The Department shall implement co-payments for the
9 Community Care Program at the federally allowable maximum
10 level (i) beginning August 1, 2013, if the Auditor General has
11 reported that the Department has failed to comply with the
12 reporting requirements of Section 2-27 of the Illinois State
13 Auditing Act; or (ii) beginning June 1, 2014, if the Auditor
14 General has reported that the Department has not undertaken
15 the required actions listed in the report required by
16 subsection (a) of Section 2-27 of the Illinois State Auditing
17 Act.

18 The Department shall continue to provide other Community
19 Care Program reports as required by statute.

20 The Department shall conduct a quarterly review of Care
21 Coordination Unit performance and adherence to service
22 guidelines. The quarterly review shall be reported to the
23 Speaker of the House of Representatives, the Minority Leader
24 of the House of Representatives, the President of the Senate,
25 and the Minority Leader of the Senate. The Department shall
26 collect and report longitudinal data on the performance of

1 each care coordination unit. Nothing in this paragraph shall
2 be construed to require the Department to identify specific
3 care coordination units.

4 In regard to community care providers, failure to comply
5 with Department on Aging policies shall be cause for
6 disciplinary action, including, but not limited to,
7 disqualification from serving Community Care Program clients.
8 Each provider, upon submission of any bill or invoice to the
9 Department for payment for services rendered, shall include a
10 notarized statement, under penalty of perjury pursuant to
11 Section 1-109 of the Code of Civil Procedure, that the
12 provider has complied with all Department policies.

13 The Director of the Department on Aging shall make
14 information available to the State Board of Elections as may
15 be required by an agreement the State Board of Elections has
16 entered into with a multi-state voter registration list
17 maintenance system.

18 Within 30 days after July 6, 2017 (the effective date of
19 Public Act 100-23), rates shall be increased to \$18.29 per
20 hour, for the purpose of increasing, by at least \$.72 per hour,
21 the wages paid by those vendors to their employees who provide
22 homemaker services. The Department shall pay an enhanced rate
23 under the Community Care Program to those in-home service
24 provider agencies that offer health insurance coverage as a
25 benefit to their direct service worker employees consistent
26 with the mandates of Public Act 95-713. For State fiscal years

1 2018 and 2019, the enhanced rate shall be \$1.77 per hour. The
2 rate shall be adjusted using actuarial analysis based on the
3 cost of care, but shall not be set below \$1.77 per hour. The
4 Department shall adopt rules, including emergency rules under
5 subsections (y) and (bb) of Section 5-45 of the Illinois
6 Administrative Procedure Act, to implement the provisions of
7 this paragraph.

8 Subject to federal approval, rates for homemaker services
9 shall be increased to \$28.07 to sustain a minimum wage of \$17
10 per hour for direct service workers. Rates in subsequent State
11 fiscal years shall be no lower than the rates put into effect
12 upon federal approval. Providers of in-home services shall be
13 required to certify to the Department that they remain in
14 compliance with the mandated wage increase for direct service
15 workers. Fringe benefits, including, but not limited to, paid
16 time off and payment for training, health insurance, travel,
17 or transportation, shall not be reduced in relation to the
18 rate increases described in this paragraph.

19 The General Assembly finds it necessary to authorize an
20 aggressive Medicaid enrollment initiative designed to maximize
21 federal Medicaid funding for the Community Care Program which
22 produces significant savings for the State of Illinois. The
23 Department on Aging shall establish and implement a Community
24 Care Program Medicaid Initiative. Under the Initiative, the
25 Department on Aging shall, at a minimum: (i) provide an
26 enhanced rate to adequately compensate care coordination units

1 to enroll eligible Community Care Program clients into
2 Medicaid; (ii) use recommendations from a stakeholder
3 committee on how best to implement the Initiative; and (iii)
4 establish requirements for State agencies to make enrollment
5 in the State's Medical Assistance program easier for seniors.

6 The Community Care Program Medicaid Enrollment Oversight
7 Subcommittee is created as a subcommittee of the Older Adult
8 Services Advisory Committee established in Section 35 of the
9 Older Adult Services Act to make recommendations on how best
10 to increase the number of medical assistance recipients who
11 are enrolled in the Community Care Program. The Subcommittee
12 shall consist of all of the following persons who must be
13 appointed within 30 days after the effective date of this
14 amendatory Act of the 100th General Assembly:

15 (1) The Director of Aging, or his or her designee, who
16 shall serve as the chairperson of the Subcommittee.

17 (2) One representative of the Department of Healthcare
18 and Family Services, appointed by the Director of
19 Healthcare and Family Services.

20 (3) One representative of the Department of Human
21 Services, appointed by the Secretary of Human Services.

22 (4) One individual representing a care coordination
23 unit, appointed by the Director of Aging.

24 (5) One individual from a non-governmental statewide
25 organization that advocates for seniors, appointed by the
26 Director of Aging.

1 (6) One individual representing Area Agencies on
2 Aging, appointed by the Director of Aging.

3 (7) One individual from a statewide association
4 dedicated to Alzheimer's care, support, and research,
5 appointed by the Director of Aging.

6 (8) One individual from an organization that employs
7 persons who provide services under the Community Care
8 Program, appointed by the Director of Aging.

9 (9) One member of a trade or labor union representing
10 persons who provide services under the Community Care
11 Program, appointed by the Director of Aging.

12 (10) One member of the Senate, who shall serve as
13 co-chairperson, appointed by the President of the Senate.

14 (11) One member of the Senate, who shall serve as
15 co-chairperson, appointed by the Minority Leader of the
16 Senate.

17 (12) One member of the House of Representatives, who
18 shall serve as co-chairperson, appointed by the Speaker of
19 the House of Representatives.

20 (13) One member of the House of Representatives, who
21 shall serve as co-chairperson, appointed by the Minority
22 Leader of the House of Representatives.

23 (14) One individual appointed by a labor organization
24 representing frontline employees at the Department of
25 Human Services.

26 The Subcommittee shall provide oversight to the Community

1 Care Program Medicaid Initiative and shall meet quarterly. At
2 each Subcommittee meeting the Department on Aging shall
3 provide the following data sets to the Subcommittee: (A) the
4 number of Illinois residents, categorized by planning and
5 service area, who are receiving services under the Community
6 Care Program and are enrolled in the State's Medical
7 Assistance Program; (B) the number of Illinois residents,
8 categorized by planning and service area, who are receiving
9 services under the Community Care Program, but are not
10 enrolled in the State's Medical Assistance Program; and (C)
11 the number of Illinois residents, categorized by planning and
12 service area, who are receiving services under the Community
13 Care Program and are eligible for benefits under the State's
14 Medical Assistance Program, but are not enrolled in the
15 State's Medical Assistance Program. In addition to this data,
16 the Department on Aging shall provide the Subcommittee with
17 plans on how the Department on Aging will reduce the number of
18 Illinois residents who are not enrolled in the State's Medical
19 Assistance Program but who are eligible for medical assistance
20 benefits. The Department on Aging shall enroll in the State's
21 Medical Assistance Program those Illinois residents who
22 receive services under the Community Care Program and are
23 eligible for medical assistance benefits but are not enrolled
24 in the State's Medicaid Assistance Program. The data provided
25 to the Subcommittee shall be made available to the public via
26 the Department on Aging's website.

1 The Department on Aging, with the involvement of the
2 Subcommittee, shall collaborate with the Department of Human
3 Services and the Department of Healthcare and Family Services
4 on how best to achieve the responsibilities of the Community
5 Care Program Medicaid Initiative.

6 The Department on Aging, the Department of Human Services,
7 and the Department of Healthcare and Family Services shall
8 coordinate and implement a streamlined process for seniors to
9 access benefits under the State's Medical Assistance Program.

10 The Subcommittee shall collaborate with the Department of
11 Human Services on the adoption of a uniform application
12 submission process. The Department of Human Services and any
13 other State agency involved with processing the medical
14 assistance application of any person enrolled in the Community
15 Care Program shall include the appropriate care coordination
16 unit in all communications related to the determination or
17 status of the application.

18 The Community Care Program Medicaid Initiative shall
19 provide targeted funding to care coordination units to help
20 seniors complete their applications for medical assistance
21 benefits. On and after July 1, 2019, care coordination units
22 shall receive no less than \$200 per completed application,
23 which rate may be included in a bundled rate for initial intake
24 services when Medicaid application assistance is provided in
25 conjunction with the initial intake process for new program
26 participants.

1 for services provided on or after the implementation of the
2 PDPM reimbursement system begins. For the purposes of this
3 amendatory Act of the 102nd General Assembly, the
4 implementation date of the PDPM reimbursement system and all
5 related provisions shall be July 1, 2022 if the following
6 conditions are met: (i) the Centers for Medicare and Medicaid
7 Services has approved corresponding changes in the
8 reimbursement system and bed assessment; and (ii) the
9 Department has filed rules to implement these changes no later
10 than June 1, 2022. Failure of the Department to file rules to
11 implement the changes provided in this amendatory Act of the
12 102nd General Assembly no later than June 1, 2022 shall result
13 in the implementation date being delayed to October 1, 2022.

14 (d) The new nursing services reimbursement methodology
15 utilizing the Patient Driven Payment Model, which shall be
16 referred to as the PDPM reimbursement system, taking effect
17 July 1, 2022, upon federal approval by the Centers for
18 Medicare and Medicaid Services, shall be based on the
19 following:

20 (1) The methodology shall be resident-centered,
21 facility-specific, cost-based, and based on guidance from
22 the Centers for Medicare and Medicaid Services.

23 (2) Costs shall be annually rebased and case mix index
24 quarterly updated. The nursing services methodology will
25 be assigned to the Medicaid enrolled residents on record
26 as of 30 days prior to the beginning of the rate period in

1 the Department's Medicaid Management Information System
2 (MMIS) as present on the last day of the second quarter
3 preceding the rate period based upon the Assessment
4 Reference Date of the Minimum Data Set (MDS).

5 (3) Regional wage adjustors based on the Health
6 Service Areas (HSA) groupings and adjusters in effect on
7 April 30, 2012 shall be included, except no adjuster shall
8 be lower than 1.06.

9 (4) PDPM nursing case mix indices in effect on March
10 1, 2022 shall be assigned to each resident class at no less
11 than 0.7858 of the Centers for Medicare and Medicaid
12 Services PDPM unadjusted case mix values, in effect on
13 March 1, 2022.

14 (5) The pool of funds available for distribution by
15 case mix and the base facility rate shall be determined
16 using the formula contained in subsection (d-1).

17 (6) The Department shall establish a variable per diem
18 staffing add-on in accordance with the most recent
19 available federal staffing report, currently the Payroll
20 Based Journal, for the same period of time, and if
21 applicable adjusted for acuity using the same quarter's
22 MDS. The Department shall rely on Payroll Based Journals
23 provided to the Department of Public Health to make a
24 determination of non-submission. If the Department is
25 notified by a facility of missing or inaccurate Payroll
26 Based Journal data or an incorrect calculation of

1 staffing, the Department must make a correction as soon as
2 the error is verified for the applicable quarter.

3 Facilities with at least 70% of the staffing indicated
4 by the STRIVE study shall be paid a per diem add-on of \$9,
5 increasing by equivalent steps for each whole percentage
6 point until the facilities reach a per diem of \$14.88.
7 Facilities with at least 80% of the staffing indicated by
8 the STRIVE study shall be paid a per diem add-on of \$14.88,
9 increasing by equivalent steps for each whole percentage
10 point until the facilities reach a per diem add-on of
11 \$23.80. Facilities with at least 92% of the staffing
12 indicated by the STRIVE study shall be paid a per diem
13 add-on of \$23.80, increasing by equivalent steps for each
14 whole percentage point until the facilities reach a per
15 diem add-on of \$29.75. Facilities with at least 100% of
16 the staffing indicated by the STRIVE study shall be paid a
17 per diem add-on of \$29.75, increasing by equivalent steps
18 for each whole percentage point until the facilities reach
19 a per diem add-on of \$35.70. Facilities with at least 110%
20 of the staffing indicated by the STRIVE study shall be
21 paid a per diem add-on of \$35.70, increasing by equivalent
22 steps for each whole percentage point until the facilities
23 reach a per diem add-on of \$38.68. Facilities with at
24 least 125% or higher of the staffing indicated by the
25 STRIVE study shall be paid a per diem add-on of \$38.68.
26 Beginning April 1, 2023, no nursing facility's variable

1 staffing per diem add-on shall be reduced by more than 5%
2 in 2 consecutive quarters. For the quarters beginning July
3 1, 2022 and October 1, 2022, no facility's variable per
4 diem staffing add-on shall be calculated at a rate lower
5 than 85% of the staffing indicated by the STRIVE study. No
6 facility below 70% of the staffing indicated by the STRIVE
7 study shall receive a variable per diem staffing add-on
8 after December 31, 2022.

9 (7) For dates of services beginning July 1, 2022, the
10 PDPM nursing component per diem for each nursing facility
11 shall be the product of the facility's (i) statewide PDPM
12 nursing base per diem rate, \$92.25, adjusted for the
13 facility average PDPM case mix index calculated quarterly
14 and (ii) the regional wage adjuster, and then add the
15 Medicaid access adjustment as defined in (e-3) of this
16 Section. Transition rates for services provided between
17 July 1, 2022 and October 1, 2023 shall be the greater of
18 the PDPM nursing component per diem or:

19 (A) for the quarter beginning July 1, 2022, the
20 RUG-IV nursing component per diem;

21 (B) for the quarter beginning October 1, 2022, the
22 sum of the RUG-IV nursing component per diem
23 multiplied by 0.80 and the PDPM nursing component per
24 diem multiplied by 0.20;

25 (C) for the quarter beginning January 1, 2023, the
26 sum of the RUG-IV nursing component per diem

1 multiplied by 0.60 and the PDPM nursing component per
2 diem multiplied by 0.40;

3 (D) for the quarter beginning April 1, 2023, the
4 sum of the RUG-IV nursing component per diem
5 multiplied by 0.40 and the PDPM nursing component per
6 diem multiplied by 0.60;

7 (E) for the quarter beginning July 1, 2023, the
8 sum of the RUG-IV nursing component per diem
9 multiplied by 0.20 and the PDPM nursing component per
10 diem multiplied by 0.80; or

11 (F) for the quarter beginning October 1, 2023 and
12 each subsequent quarter, the transition rate shall end
13 and a nursing facility shall be paid 100% of the PDPM
14 nursing component per diem.

15 (d-1) Calculation of base year Statewide RUG-IV nursing
16 base per diem rate.

17 (1) Base rate spending pool shall be:

18 (A) The base year resident days which are
19 calculated by multiplying the number of Medicaid
20 residents in each nursing home as indicated in the MDS
21 data defined in paragraph (4) by 365.

22 (B) Each facility's nursing component per diem in
23 effect on July 1, 2012 shall be multiplied by
24 subsection (A).

25 (C) Thirteen million is added to the product of
26 subparagraph (A) and subparagraph (B) to adjust for

1 the exclusion of nursing homes defined in paragraph
2 (5).

3 (2) For each nursing home with Medicaid residents as
4 indicated by the MDS data defined in paragraph (4),
5 weighted days adjusted for case mix and regional wage
6 adjustment shall be calculated. For each home this
7 calculation is the product of:

8 (A) Base year resident days as calculated in
9 subparagraph (A) of paragraph (1).

10 (B) The nursing home's regional wage adjustor
11 based on the Health Service Areas (HSA) groupings and
12 adjustors in effect on April 30, 2012.

13 (C) Facility weighted case mix which is the number
14 of Medicaid residents as indicated by the MDS data
15 defined in paragraph (4) multiplied by the associated
16 case weight for the RUG-IV 48 grouper model using
17 standard RUG-IV procedures for index maximization.

18 (D) The sum of the products calculated for each
19 nursing home in subparagraphs (A) through (C) above
20 shall be the base year case mix, rate adjusted
21 weighted days.

22 (3) The Statewide RUG-IV nursing base per diem rate:

23 (A) on January 1, 2014 shall be the quotient of the
24 paragraph (1) divided by the sum calculated under
25 subparagraph (D) of paragraph (2);

26 (B) on and after July 1, 2014 and until July 1,

1 2022, shall be the amount calculated under
2 subparagraph (A) of this paragraph (3) plus \$1.76; and
3 (C) beginning July 1, 2022 and thereafter, \$7
4 shall be added to the amount calculated under
5 subparagraph (B) of this paragraph (3) of this
6 Section.

7 (4) Minimum Data Set (MDS) comprehensive assessments
8 for Medicaid residents on the last day of the quarter used
9 to establish the base rate.

10 (5) Nursing facilities designated as of July 1, 2012
11 by the Department as "Institutions for Mental Disease"
12 shall be excluded from all calculations under this
13 subsection. The data from these facilities shall not be
14 used in the computations described in paragraphs (1)
15 through (4) above to establish the base rate.

16 (e) Beginning July 1, 2014, the Department shall allocate
17 funding in the amount up to \$10,000,000 for per diem add-ons to
18 the RUGS methodology for dates of service on and after July 1,
19 2014:

20 (1) \$0.63 for each resident who scores in I4200
21 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

22 (2) \$2.67 for each resident who scores either a "1" or
23 "2" in any items S1200A through S1200I and also scores in
24 RUG groups PA1, PA2, BA1, or BA2.

25 (e-1) (Blank).

26 (e-2) For dates of services beginning January 1, 2014 and

1 ending September 30, 2023, the RUG-IV nursing component per
2 diem for a nursing home shall be the product of the statewide
3 RUG-IV nursing base per diem rate, the facility average case
4 mix index, and the regional wage adjustor. For dates of
5 service beginning July 1, 2022 and ending September 30, 2023,
6 the Medicaid access adjustment described in subsection (e-3)
7 shall be added to the product.

8 (e-3) A Medicaid Access Adjustment of \$4 adjusted for the
9 facility average PDPM case mix index calculated quarterly
10 shall be added to the statewide PDPM nursing per diem for all
11 facilities with annual Medicaid bed days of at least 70% of all
12 occupied bed days adjusted quarterly. For each new calendar
13 year and for the 6-month period beginning July 1, 2022, the
14 percentage of a facility's occupied bed days comprised of
15 Medicaid bed days shall be determined by the Department
16 quarterly. For dates of service beginning January 1, 2023, the
17 Medicaid Access Adjustment shall be increased to \$4.75. This
18 subsection shall be inoperative on and after January 1, 2028.

19 (e-4) Subject to federal approval, the Department shall
20 increase the rate add-on at paragraph (7) subsection (a) under
21 89 Ill. Adm. Code 147.335 for ventilator services from \$208
22 per day to \$481 per day. Payment is subject to the criteria and
23 requirements under 89 Ill. Adm. Code 147.335.

24 (f) (Blank).

25 (g) Notwithstanding any other provision of this Code, on
26 and after July 1, 2012, for facilities not designated by the

1 Department of Healthcare and Family Services as "Institutions
2 for Mental Disease", rates effective May 1, 2011 shall be
3 adjusted as follows:

4 (1) (Blank);

5 (2) (Blank);

6 (3) Facility rates for the capital and support
7 components shall be reduced by 1.7%.

8 (h) Notwithstanding any other provision of this Code, on
9 and after July 1, 2012, nursing facilities designated by the
10 Department of Healthcare and Family Services as "Institutions
11 for Mental Disease" and "Institutions for Mental Disease" that
12 are facilities licensed under the Specialized Mental Health
13 Rehabilitation Act of 2013 shall have the nursing,
14 socio-developmental, capital, and support components of their
15 reimbursement rate effective May 1, 2011 reduced in total by
16 2.7%.

17 (i) On and after July 1, 2014, the reimbursement rates for
18 the support component of the nursing facility rate for
19 facilities licensed under the Nursing Home Care Act as skilled
20 or intermediate care facilities shall be the rate in effect on
21 June 30, 2014 increased by 8.17%.

22 (j) Notwithstanding any other provision of law, subject to
23 federal approval, effective July 1, 2019, sufficient funds
24 shall be allocated for changes to rates for facilities
25 licensed under the Nursing Home Care Act as skilled nursing
26 facilities or intermediate care facilities for dates of

1 services on and after July 1, 2019: (i) to establish, through
2 June 30, 2022 a per diem add-on to the direct care per diem
3 rate not to exceed \$70,000,000 annually in the aggregate
4 taking into account federal matching funds for the purpose of
5 addressing the facility's unique staffing needs, adjusted
6 quarterly and distributed by a weighted formula based on
7 Medicaid bed days on the last day of the second quarter
8 preceding the quarter for which the rate is being adjusted.
9 Beginning July 1, 2022, the annual \$70,000,000 described in
10 the preceding sentence shall be dedicated to the variable per
11 diem add-on for staffing under paragraph (6) of subsection
12 (d); and (ii) in an amount not to exceed \$170,000,000 annually
13 in the aggregate taking into account federal matching funds to
14 permit the support component of the nursing facility rate to
15 be updated as follows:

16 (1) 80%, or \$136,000,000, of the funds shall be used
17 to update each facility's rate in effect on June 30, 2019
18 using the most recent cost reports on file, which have had
19 a limited review conducted by the Department of Healthcare
20 and Family Services and will not hold up enacting the rate
21 increase, with the Department of Healthcare and Family
22 Services.

23 (2) After completing the calculation in paragraph (1),
24 any facility whose rate is less than the rate in effect on
25 June 30, 2019 shall have its rate restored to the rate in
26 effect on June 30, 2019 from the 20% of the funds set

1 aside.

2 (3) The remainder of the 20%, or \$34,000,000, shall be
3 used to increase each facility's rate by an equal
4 percentage.

5 (k) During the first quarter of State Fiscal Year 2020,
6 the Department of Healthcare of Family Services must convene a
7 technical advisory group consisting of members of all trade
8 associations representing Illinois skilled nursing providers
9 to discuss changes necessary with federal implementation of
10 Medicare's Patient-Driven Payment Model. Implementation of
11 Medicare's Patient-Driven Payment Model shall, by September 1,
12 2020, end the collection of the MDS data that is necessary to
13 maintain the current RUG-IV Medicaid payment methodology. The
14 technical advisory group must consider a revised reimbursement
15 methodology that takes into account transparency,
16 accountability, actual staffing as reported under the
17 federally required Payroll Based Journal system, changes to
18 the minimum wage, adequacy in coverage of the cost of care, and
19 a quality component that rewards quality improvements.

20 (1) The Department shall establish per diem add-on
21 payments to improve the quality of care delivered by
22 facilities, including:

23 (1) Incentive payments determined by facility
24 performance on specified quality measures in an initial
25 amount of \$70,000,000. Nothing in this subsection shall be
26 construed to limit the quality of care payments in the

1 aggregate statewide to \$70,000,000, and, if quality of
2 care has improved across nursing facilities, the
3 Department shall adjust those add-on payments accordingly.
4 The quality payment methodology described in this
5 subsection must be used for at least State Fiscal Year
6 2023. Beginning with the quarter starting July 1, 2023,
7 the Department may add, remove, or change quality metrics
8 and make associated changes to the quality payment
9 methodology as outlined in subparagraph (E). Facilities
10 designated by the Centers for Medicare and Medicaid
11 Services as a special focus facility or a hospital-based
12 nursing home do not qualify for quality payments.

13 (A) Each quality pool must be distributed by
14 assigning a quality weighted score for each nursing
15 home which is calculated by multiplying the nursing
16 home's quality base period Medicaid days by the
17 nursing home's star rating weight in that period.

18 (B) Star rating weights are assigned based on the
19 nursing home's star rating for the LTS quality star
20 rating. As used in this subparagraph, "LTS quality
21 star rating" means the long-term stay quality rating
22 for each nursing facility, as assigned by the Centers
23 for Medicare and Medicaid Services under the Five-Star
24 Quality Rating System. The rating is a number ranging
25 from 0 (lowest) to 5 (highest).

26 (i) Zero-star or one-star rating has a weight

1 of 0.

2 (ii) Two-star rating has a weight of 0.75.

3 (iii) Three-star rating has a weight of 1.5.

4 (iv) Four-star rating has a weight of 2.5.

5 (v) Five-star rating has a weight of 3.5.

6 (C) Each nursing home's quality weight score is
7 divided by the sum of all quality weight scores for
8 qualifying nursing homes to determine the proportion
9 of the quality pool to be paid to the nursing home.

10 (D) The quality pool is no less than \$70,000,000
11 annually or \$17,500,000 per quarter. The Department
12 shall publish on its website the estimated payments
13 and the associated weights for each facility 45 days
14 prior to when the initial payments for the quarter are
15 to be paid. The Department shall assign each facility
16 the most recent and applicable quarter's STAR value
17 unless the facility notifies the Department within 15
18 days of an issue and the facility provides reasonable
19 evidence demonstrating its timely compliance with
20 federal data submission requirements for the quarter
21 of record. If such evidence cannot be provided to the
22 Department, the STAR rating assigned to the facility
23 shall be reduced by one from the prior quarter.

24 (E) The Department shall review quality metrics
25 used for payment of the quality pool and make
26 recommendations for any associated changes to the

1 methodology for distributing quality pool payments in
2 consultation with associations representing long-term
3 care providers, consumer advocates, organizations
4 representing workers of long-term care facilities, and
5 payors. The Department may establish, by rule, changes
6 to the methodology for distributing quality pool
7 payments.

8 (F) The Department shall disburse quality pool
9 payments from the Long-Term Care Provider Fund on a
10 monthly basis in amounts proportional to the total
11 quality pool payment determined for the quarter.

12 (G) The Department shall publish any changes in
13 the methodology for distributing quality pool payments
14 prior to the beginning of the measurement period or
15 quality base period for any metric added to the
16 distribution's methodology.

17 (2) Payments based on CNA tenure, promotion, and CNA
18 training for the purpose of increasing CNA compensation.
19 It is the intent of this subsection that payments made in
20 accordance with this paragraph be directly incorporated
21 into increased compensation for CNAs. As used in this
22 paragraph, "CNA" means a certified nursing assistant as
23 that term is described in Section 3-206 of the Nursing
24 Home Care Act, Section 3-206 of the ID/DD Community Care
25 Act, and Section 3-206 of the MC/DD Act. The Department
26 shall establish, by rule, payments to nursing facilities

1 equal to Medicaid's share of the tenure wage increments
2 specified in this paragraph for all reported CNA employee
3 hours compensated according to a posted schedule
4 consisting of increments at least as large as those
5 specified in this paragraph. The increments are as
6 follows: an additional \$1.50 per hour for CNAs with at
7 least one and less than 2 years' experience plus another
8 \$1 per hour for each additional year of experience up to a
9 maximum of \$6.50 for CNAs with at least 6 years of
10 experience. For purposes of this paragraph, Medicaid's
11 share shall be the ratio determined by paid Medicaid bed
12 days divided by total bed days for the applicable time
13 period used in the calculation. In addition, and additive
14 to any tenure increments paid as specified in this
15 paragraph, the Department shall establish, by rule,
16 payments supporting Medicaid's share of the
17 promotion-based wage increments for CNA employee hours
18 compensated for that promotion with at least a \$1.50
19 hourly increase. Medicaid's share shall be established as
20 it is for the tenure increments described in this
21 paragraph. Qualifying promotions shall be defined by the
22 Department in rules for an expected 10-15% subset of CNAs
23 assigned intermediate, specialized, or added roles such as
24 CNA trainers, CNA scheduling "captains", and CNA
25 specialists for resident conditions like dementia or
26 memory care or behavioral health.

1 (m) The Department shall work with nursing facility
2 industry representatives to design policies and procedures to
3 permit facilities to address the integrity of data from
4 federal reporting sites used by the Department in setting
5 facility rates.

6 (Source: P.A. 101-10, eff. 6-5-19; 101-348, eff. 8-9-19;
7 102-77, eff. 7-9-21; 102-558, eff. 8-20-21; 102-1035, eff.
8 5-31-22; 102-1118, eff. 1-18-23.)

9 ARTICLE 55.

10 Section 55-5. The Illinois Public Aid Code is amended by
11 adding Section 5-5i as follows:

12 (305 ILCS 5/5-5i new)

13 Sec. 5-5i. Rate increase for speech, physical, and
14 occupational therapy services. Effective upon federal
15 approval, the Department shall increase reimbursement rates
16 for speech therapy services, physical therapy services, and
17 occupational therapy services provided by licensed
18 speech-language pathologists and speech-language pathology
19 assistants, physical therapists and physical therapy
20 assistants, and occupational therapists and certified
21 occupational therapy assistants, including those in their
22 clinical fellowship, by 14.2%.

1 ARTICLE 60.

2 Section 60-5. The Illinois Public Aid Code is amended by
3 adding Section 5-35.5 as follows:

4 (305 ILCS 5/5-35.5 new)

5 Sec. 5-35.5. Personal needs allowance; nursing home
6 residents. Subject to federal approval, for a person who is a
7 resident in a facility licensed under the Nursing Home Care
8 Act for whom payments are made under this Article throughout a
9 month and who is determined to be eligible for medical
10 assistance under this Article, the monthly personal needs
11 allowance shall be \$60.

12 ARTICLE 65.

13 Section 65-5. The Rebuild Illinois Mental Health Workforce
14 Act is amended by changing Sections 20-10 and 20-20 and by
15 adding Section 20-22 as follows:

16 (305 ILCS 66/20-10)

17 Sec. 20-10. Medicaid funding for community mental health
18 services. Medicaid funding for the specific community mental
19 health services listed in this Act shall be adjusted and paid
20 as set forth in this Act. Such payments shall be paid in
21 addition to the base Medicaid reimbursement rate and add-on

1 payment rates per service unit.

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

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

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

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

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

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

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

1 (5) Medicaid user-based directed payments.

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

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

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

25 (B) For each State fiscal year, a monthly directed
26 payment shall be paid to each community mental health

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

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

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

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

26 (b) Subject to federal approval, a one-time directed

1 payment must be made in calendar year 2023 for community
2 mental health services provided by community mental health
3 providers. The one-time directed payment shall be for an
4 amount appropriated for these purposes. The one-time directed
5 payment shall be for services for Integrated Assessment and
6 Treatment Planning and other intensive services, including,
7 but not limited to, services for Mobile Crisis Response,
8 crisis intervention, and medication monitoring. The amounts
9 and services used for designing and distributing these
10 one-time directed payments shall not be construed to require
11 any future rate or funding increases for the same or other
12 mental health services.

13 (c) The following payment adjustments shall be made:

14 (1) Subject to federal approval, the Department shall
15 introduce rate increases to behavioral health services no
16 less than by the following targeted pool for the specified
17 services provided by community mental health centers:

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

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

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

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

23 (E) Family Therapy, \$500,000;

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

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

26 (2) Rate increases shall be determined with

1 significant input from Illinois behavioral health trade
2 associations and advocates. The Department must use
3 service units delivered under the fee-for-service and
4 managed care programs by community mental health centers
5 during State Fiscal Year 2022. These services are used for
6 distributing the targeted pools and setting rates but do
7 not prohibit the Department from paying providers not
8 enrolled as community mental health centers the same rate
9 if providing the same services.

10 (d) Rate simplification for team-based services.

11 (1) The Department shall work with stakeholders to
12 redesign reimbursement rates for behavioral health
13 team-based services established under the Rehabilitation
14 Option of the Illinois Medicaid State Plan supporting
15 individuals with chronic or complex behavioral health
16 conditions and crisis services. Subject to federal
17 approval, the redesigned rates shall seek to introduce
18 bundled payment systems that minimize provider claiming
19 activities while transitioning the focus of treatment
20 towards metrics and outcomes. Federally approved rate
21 models shall seek to ensure reimbursement levels are no
22 less than the State's total reimbursement for similar
23 services in calendar year 2023, including all service
24 level payments, add-ons, and all other payments specified
25 in this Section.

26 (2) In State Fiscal Year 2024, the Department shall

1 identify an existing, or establish a new, Behavioral
2 Health Outcomes Stakeholder Workgroup to help inform the
3 identification of metrics and outcomes for team-based
4 services.

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

10 (Source: P.A. 102-699, eff. 4-19-22; 102-1118, eff. 1-18-23;
11 revised 1-23-23.)

12 (305 ILCS 66/20-20)

13 Sec. 20-20. Base Medicaid rates or add-on payments.

14 (a) For services under subsection (a) of Section 20-10: ~~—~~

15 No base Medicaid rate or Medicaid rate add-on payment or
16 any other payment for the provision of Medicaid community
17 mental health services in place on July 1, 2021 shall be
18 diminished or changed to make the reimbursement changes
19 required by this Act. Any payments required under this Act
20 that are delayed due to implementation challenges or federal
21 approval shall be made retroactive to July 1, 2022 for the full
22 amount required by this Act.

23 (b) For directed payments under subsection (b) of Section
24 20-10: ~~—~~

25 No base Medicaid rate payment or any other payment for the

1 provision of Medicaid community mental health services in
2 place on January 1, 2023 shall be diminished or changed to make
3 the reimbursement changes required by this Act. The Department
4 of Healthcare and Family Services must pay the directed
5 payment in one installment within 60 days of receiving federal
6 approval.

7 (c) For directed payments under subsection (c) of Section
8 20-10:

9 No base Medicaid rate payment or any other payment for the
10 provision of Medicaid community mental health services in
11 place on January 1, 2023 shall be diminished or changed to make
12 the reimbursement changes required by this amendatory Act of
13 the 103rd General Assembly. Any payments required under this
14 amendatory Act of the 103rd General Assembly that are delayed
15 due to implementation challenges or federal approval shall be
16 made retroactive to no later than January 1, 2024 for the full
17 amount required by this amendatory Act of the 103rd General
18 Assembly.

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

20 (305 ILCS 66/20-22 new)

21 Sec. 20-22. Implementation plan for cost reporting.

22 (a) For the purpose of understanding behavioral health
23 services cost structures and their impact on the Illinois
24 Medical Assistance Program, the Department shall engage
25 stakeholders to develop a plan for the regular collection of

1 cost reporting for all entity-based providers of behavioral
2 health services reimbursed under the Rehabilitation or
3 Prevention authorities of the Illinois Medicaid State Plan.
4 Data shall be used to inform on the effectiveness and
5 efficiency of Illinois Medicaid rates. The plan at minimum
6 should consider the following:

7 (1) alignment with certified community behavioral
8 health clinic requirements, standards, policies, and
9 procedures;

10 (2) inclusion of prospective costs to measure what is
11 needed to increase services and capacity;

12 (3) consideration of differences in collection and
13 policies based on the size of providers;

14 (4) consideration of additional administrative time
15 and costs;

16 (5) goals, purposes, and usage of data collected from
17 cost reports;

18 (6) inclusion of qualitative data in addition to
19 quantitative data;

20 (7) technical assistance for providers for completing
21 cost reports including initial training by the Department
22 for providers; and

23 (8) an implementation timeline that allows an initial
24 grace period for providers to adjust internal procedures
25 and data collection.

26 Details from collected cost reports shall be made publicly

1 available on the Department's website and costs shall be used
2 to ensure the effectiveness and efficiency of Illinois
3 Medicaid rates.

4 (b) The Department and stakeholders shall develop a plan
5 by April 1, 2024. The Department shall engage stakeholders on
6 implementation of the plan.

7 ARTICLE 70.

8 Section 70-5. The Illinois Public Aid Code is amended by
9 changing Section 5-4.2 as follows:

10 (305 ILCS 5/5-4.2)

11 Sec. 5-4.2. Ambulance services payments.

12 (a) For ambulance services provided to a recipient of aid
13 under this Article on or after January 1, 1993, the Illinois
14 Department shall reimburse ambulance service providers at
15 rates calculated in accordance with this Section. It is the
16 intent of the General Assembly to provide adequate
17 reimbursement for ambulance services so as to ensure adequate
18 access to services for recipients of aid under this Article
19 and to provide appropriate incentives to ambulance service
20 providers to provide services in an efficient and
21 cost-effective manner. Thus, it is the intent of the General
22 Assembly that the Illinois Department implement a
23 reimbursement system for ambulance services that, to the

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

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

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

22 (c-1) For purposes of this Section, "ground ambulance
23 service" means medical transportation services that are
24 described as ground ambulance services by the Centers for
25 Medicare and Medicaid Services and provided in a vehicle that
26 is licensed as an ambulance by the Illinois Department of

1 Public Health pursuant to the Emergency Medical Services (EMS)
2 Systems Act.

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

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

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

22 (c-5) For purposes of this Section, "air ambulance
23 service" means medical transport by helicopter or airplane for
24 patients, as defined in 29 U.S.C. 1185f(c) (1), and any service
25 that is described as an air ambulance service by the federal
26 Centers for Medicare and Medicaid Services.

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

4 (e) Beginning with services rendered on or after July 1,
5 2008, all providers of non-emergency medi-car and service car
6 transportation must certify that the driver and employee
7 attendant, as applicable, have completed a safety program
8 approved by the Department to protect both the patient and the
9 driver, prior to transporting a patient. The provider must
10 maintain this certification in its records. The provider shall
11 produce such documentation upon demand by the Department or
12 its representative. Failure to produce documentation of such
13 training shall result in recovery of any payments made by the
14 Department for services rendered by a non-certified driver or
15 employee attendant. Medi-car and service car providers must
16 maintain legible documentation in their records of the driver
17 and, as applicable, employee attendant that actually
18 transported the patient. Providers must recertify all drivers
19 and employee attendants every 3 years. If they meet the
20 established training components set forth by the Department,
21 providers of non-emergency medi-car and service car
22 transportation that are either directly or through an
23 affiliated company licensed by the Department of Public Health
24 shall be approved by the Department to have in-house safety
25 programs for training their own staff.

26 Notwithstanding the requirements above, any public

1 transportation provider of medi-car and service car
2 transportation that receives federal funding under 49 U.S.C.
3 5307 and 5311 need not certify its drivers and employee
4 attendants under this Section, since safety training is
5 already federally mandated.

6 (f) With respect to any policy or program administered by
7 the Department or its agent regarding approval of
8 non-emergency medical transportation by ground ambulance
9 service providers, including, but not limited to, the
10 Non-Emergency Transportation Services Prior Approval Program
11 (NETSPAP), the Department shall establish by rule a process by
12 which ground ambulance service providers of non-emergency
13 medical transportation may appeal any decision by the
14 Department or its agent for which no denial was received prior
15 to the time of transport that either (i) denies a request for
16 approval for payment of non-emergency transportation by means
17 of ground ambulance service or (ii) grants a request for
18 approval of non-emergency transportation by means of ground
19 ambulance service at a level of service that entitles the
20 ground ambulance service provider to a lower level of
21 compensation from the Department than the ground ambulance
22 service provider would have received as compensation for the
23 level of service requested. The rule shall be filed by
24 December 15, 2012 and shall provide that, for any decision
25 rendered by the Department or its agent on or after the date
26 the rule takes effect, the ground ambulance service provider

1 shall have 60 days from the date the decision is received to
2 file an appeal. The rule established by the Department shall
3 be, insofar as is practical, consistent with the Illinois
4 Administrative Procedure Act. The Director's decision on an
5 appeal under this Section shall be a final administrative
6 decision subject to review under the Administrative Review
7 Law.

8 (f-5) Beginning 90 days after July 20, 2012 (the effective
9 date of Public Act 97-842), (i) no denial of a request for
10 approval for payment of non-emergency transportation by means
11 of ground ambulance service, and (ii) no approval of
12 non-emergency transportation by means of ground ambulance
13 service at a level of service that entitles the ground
14 ambulance service provider to a lower level of compensation
15 from the Department than would have been received at the level
16 of service submitted by the ground ambulance service provider,
17 may be issued by the Department or its agent unless the
18 Department has submitted the criteria for determining the
19 appropriateness of the transport for first notice publication
20 in the Illinois Register pursuant to Section 5-40 of the
21 Illinois Administrative Procedure Act.

22 (f-6) Within 90 days after the effective date of this
23 amendatory Act of the 102nd General Assembly and subject to
24 federal approval, the Department shall file rules to allow for
25 the approval of ground ambulance services when the sole
26 purpose of the transport is for the navigation of stairs or the

1 assisting or lifting of a patient at a medical facility or
2 during a medical appointment in instances where the Department
3 or a contracted Medicaid managed care organization or their
4 transportation broker is unable to secure transportation
5 through any other transportation provider.

6 (f-7) For non-emergency ground ambulance claims properly
7 denied under Department policy at the time the claim is filed
8 due to failure to submit a valid Medical Certification for
9 Non-Emergency Ambulance on and after December 15, 2012 and
10 prior to January 1, 2021, the Department shall allot
11 \$2,000,000 to a pool to reimburse such claims if the provider
12 proves medical necessity for the service by other means.
13 Providers must submit any such denied claims for which they
14 seek compensation to the Department no later than December 31,
15 2021 along with documentation of medical necessity. No later
16 than May 31, 2022, the Department shall determine for which
17 claims medical necessity was established. Such claims for
18 which medical necessity was established shall be paid at the
19 rate in effect at the time of the service, provided the
20 \$2,000,000 is sufficient to pay at those rates. If the pool is
21 not sufficient, claims shall be paid at a uniform percentage
22 of the applicable rate such that the pool of \$2,000,000 is
23 exhausted. The appeal process described in subsection (f)
24 shall not be applicable to the Department's determinations
25 made in accordance with this subsection.

26 (g) Whenever a patient covered by a medical assistance

1 program under this Code or by another medical program
2 administered by the Department, including a patient covered
3 under the State's Medicaid managed care program, is being
4 transported from a facility and requires non-emergency
5 transportation including ground ambulance, medi-car, or
6 service car transportation, a Physician Certification
7 Statement as described in this Section shall be required for
8 each patient. Facilities shall develop procedures for a
9 licensed medical professional to provide a written and signed
10 Physician Certification Statement. The Physician Certification
11 Statement shall specify the level of transportation services
12 needed and complete a medical certification establishing the
13 criteria for approval of non-emergency ambulance
14 transportation, as published by the Department of Healthcare
15 and Family Services, that is met by the patient. This
16 certification shall be completed prior to ordering the
17 transportation service and prior to patient discharge. The
18 Physician Certification Statement is not required prior to
19 transport if a delay in transport can be expected to
20 negatively affect the patient outcome. If the ground ambulance
21 provider, medi-car provider, or service car provider is unable
22 to obtain the required Physician Certification Statement
23 within 10 calendar days following the date of the service, the
24 ground ambulance provider, medi-car provider, or service car
25 provider must document its attempt to obtain the requested
26 certification and may then submit the claim for payment.

1 Acceptable documentation includes a signed return receipt from
2 the U.S. Postal Service, facsimile receipt, email receipt, or
3 other similar service that evidences that the ground ambulance
4 provider, medi-car provider, or service car provider attempted
5 to obtain the required Physician Certification Statement.

6 The medical certification specifying the level and type of
7 non-emergency transportation needed shall be in the form of
8 the Physician Certification Statement on a standardized form
9 prescribed by the Department of Healthcare and Family
10 Services. Within 75 days after July 27, 2018 (the effective
11 date of Public Act 100-646), the Department of Healthcare and
12 Family Services shall develop a standardized form of the
13 Physician Certification Statement specifying the level and
14 type of transportation services needed in consultation with
15 the Department of Public Health, Medicaid managed care
16 organizations, a statewide association representing ambulance
17 providers, a statewide association representing hospitals, 3
18 statewide associations representing nursing homes, and other
19 stakeholders. The Physician Certification Statement shall
20 include, but is not limited to, the criteria necessary to
21 demonstrate medical necessity for the level of transport
22 needed as required by (i) the Department of Healthcare and
23 Family Services and (ii) the federal Centers for Medicare and
24 Medicaid Services as outlined in the Centers for Medicare and
25 Medicaid Services' Medicare Benefit Policy Manual, Pub.
26 100-02, Chap. 10, Sec. 10.2.1, et seq. The use of the Physician

1 Certification Statement shall satisfy the obligations of
2 hospitals under Section 6.22 of the Hospital Licensing Act and
3 nursing homes under Section 2-217 of the Nursing Home Care
4 Act. Implementation and acceptance of the Physician
5 Certification Statement shall take place no later than 90 days
6 after the issuance of the Physician Certification Statement by
7 the Department of Healthcare and Family Services.

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

15 Beginning October 1, 2018, the Department of Healthcare
16 and Family Services shall collect data from Medicaid managed
17 care organizations and transportation brokers, including the
18 Department's NETSPAP broker, regarding denials and appeals
19 related to the missing or incomplete Physician Certification
20 Statement forms and overall compliance with this subsection.
21 The Department of Healthcare and Family Services shall publish
22 quarterly results on its website within 15 days following the
23 end of each quarter.

24 (h) On and after July 1, 2012, the Department shall reduce
25 any rate of reimbursement for services or other payments or
26 alter any methodologies authorized by this Code to reduce any

1 rate of reimbursement for services or other payments in
2 accordance with Section 5-5e.

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

9 (j) Subject to federal approval, the Department shall
10 increase the base rate of reimbursement for both base charges
11 and mileage charges for medical transportation services
12 provided by means of an air ambulance to a level not lower than
13 50% of the Medicare ambulance fee schedule rates, by
14 designated Medicare locality, in effect on January 1, 2023.

15 (Source: P.A. 101-81, eff. 7-12-19; 101-649, eff. 7-7-20;
16 102-364, eff. 1-1-22; 102-650, eff. 8-27-21; 102-813, eff.
17 5-13-22; 102-1037, eff. 6-2-22.)

18 ARTICLE 75.

19 Section 75-5. The Illinois Public Aid Code is amended by
20 changing Section 5-5.4h as follows:

21 (305 ILCS 5/5-5.4h)

22 Sec. 5-5.4h. Medicaid reimbursement for medically complex
23 for the developmentally disabled facilities licensed under the

1 MC/DD Act.

2 (a) Facilities licensed as medically complex for the
3 developmentally disabled facilities that serve severely and
4 chronically ill patients shall have a specific reimbursement
5 system designed to recognize the characteristics and needs of
6 the patients they serve.

7 (b) For dates of services starting July 1, 2013 and until a
8 new reimbursement system is designed, medically complex for
9 the developmentally disabled facilities that meet the
10 following criteria:

11 (1) serve exceptional care patients; and

12 (2) have 30% or more of their patients receiving
13 ventilator care;

14 shall receive Medicaid reimbursement on a 30-day expedited
15 schedule.

16 (c) Subject to federal approval of changes to the Title
17 XIX State Plan, for dates of services starting July 1, 2014
18 through March 31, 2019, medically complex for the
19 developmentally disabled facilities which meet the criteria in
20 subsection (b) of this Section shall receive a per diem rate
21 for clinically complex residents of \$304. Clinically complex
22 residents on a ventilator shall receive a per diem rate of
23 \$669. Subject to federal approval of changes to the Title XIX
24 State Plan, for dates of services starting April 1, 2019,
25 medically complex for the developmentally disabled facilities
26 must be reimbursed an exceptional care per diem rate, instead

1 of the base rate, for services to residents with complex or
2 extensive medical needs. Exceptional care per diem rates must
3 be paid for the conditions or services specified under
4 subsection (f) at the following per diem rates: Tier 1 \$326,
5 Tier 2 \$546, and Tier 3 \$735. Subject to federal approval, each
6 tier rate shall be increased 6% over the amount in effect on
7 the effective date of this amendatory Act of the 103rd General
8 Assembly. Any reimbursement increases applied to the base rate
9 to providers licensed under the ID/DD Community Care Act must
10 also be applied in an equivalent manner to each tier of
11 exceptional care per diem rates for medically complex for the
12 developmentally disabled facilities.

13 (d) For residents on a ventilator pursuant to subsection
14 (c) or subsection (f), facilities shall have a policy
15 documenting their method of routine assessment of a resident's
16 weaning potential with interventions implemented noted in the
17 resident's medical record.

18 (e) For services provided prior to April 1, 2019 and for
19 the purposes of this Section, a resident is considered
20 clinically complex if the resident requires at least one of
21 the following medical services:

22 (1) Tracheostomy care with dependence on mechanical
23 ventilation for a minimum of 6 hours each day.

24 (2) Tracheostomy care requiring suctioning at least
25 every 6 hours, room air mist or oxygen as needed, and
26 dependence on one of the treatment procedures listed under

1 paragraph (4) excluding the procedure listed in
2 subparagraph (A) of paragraph (4).

3 (3) Total parenteral nutrition or other intravenous
4 nutritional support and one of the treatment procedures
5 listed under paragraph (4).

6 (4) The following treatment procedures apply to the
7 conditions in paragraphs (2) and (3) of this subsection:

8 (A) Intermittent suctioning at least every 8 hours
9 and room air mist or oxygen as needed.

10 (B) Continuous intravenous therapy including
11 administration of therapeutic agents necessary for
12 hydration or of intravenous pharmaceuticals; or
13 intravenous pharmaceutical administration of more than
14 one agent via a peripheral or central line, without
15 continuous infusion.

16 (C) Peritoneal dialysis treatments requiring at
17 least 4 exchanges every 24 hours.

18 (D) Tube feeding via nasogastric or gastrostomy
19 tube.

20 (E) Other medical technologies required
21 continuously, which in the opinion of the attending
22 physician require the services of a professional
23 nurse.

24 (f) Complex or extensive medical needs for exceptional
25 care reimbursement. The conditions and services used for the
26 purposes of this Section have the same meanings as ascribed to

1 those conditions and services under the Minimum Data Set (MDS)
2 Resident Assessment Instrument (RAI) and specified in the most
3 recent manual. Instead of submitting minimum data set
4 assessments to the Department, medically complex for the
5 developmentally disabled facilities must document within each
6 resident's medical record the conditions or services using the
7 minimum data set documentation standards and requirements to
8 qualify for exceptional care reimbursement.

9 (1) Tier 1 reimbursement is for residents who are
10 receiving at least 51% of their caloric intake via a
11 feeding tube.

12 (2) Tier 2 reimbursement is for residents who are
13 receiving tracheostomy care without a ventilator.

14 (3) Tier 3 reimbursement is for residents who are
15 receiving tracheostomy care and ventilator care.

16 (g) For dates of services starting April 1, 2019,
17 reimbursement calculations and direct payment for services
18 provided by medically complex for the developmentally disabled
19 facilities are the responsibility of the Department of
20 Healthcare and Family Services instead of the Department of
21 Human Services. Appropriations for medically complex for the
22 developmentally disabled facilities must be shifted from the
23 Department of Human Services to the Department of Healthcare
24 and Family Services. Nothing in this Section prohibits the
25 Department of Healthcare and Family Services from paying more
26 than the rates specified in this Section. The rates in this

1 Section must be interpreted as a minimum amount. Any
2 reimbursement increases applied to providers licensed under
3 the ID/DD Community Care Act must also be applied in an
4 equivalent manner to medically complex for the developmentally
5 disabled facilities.

6 (h) The Department of Healthcare and Family Services shall
7 pay the rates in effect on March 31, 2019 until the changes
8 made to this Section by this amendatory Act of the 100th
9 General Assembly have been approved by the Centers for
10 Medicare and Medicaid Services of the U.S. Department of
11 Health and Human Services.

12 (i) The Department of Healthcare and Family Services may
13 adopt rules as allowed by the Illinois Administrative
14 Procedure Act to implement this Section; however, the
15 requirements of this Section must be implemented by the
16 Department of Healthcare and Family Services even if the
17 Department of Healthcare and Family Services has not adopted
18 rules by the implementation date of April 1, 2019.

19 (Source: P.A. 100-646, eff. 7-27-18.)

20 ARTICLE 80.

21 Section 80-5. The Illinois Public Aid Code is amended by
22 changing Section 5-4.2 as follows:

23 (305 ILCS 5/5-4.2)

1 Sec. 5-4.2. Ambulance services payments.

2 (a) For ambulance services provided to a recipient of aid
3 under this Article on or after January 1, 1993, the Illinois
4 Department shall reimburse ambulance service providers at
5 rates calculated in accordance with this Section. It is the
6 intent of the General Assembly to provide adequate
7 reimbursement for ambulance services so as to ensure adequate
8 access to services for recipients of aid under this Article
9 and to provide appropriate incentives to ambulance service
10 providers to provide services in an efficient and
11 cost-effective manner. Thus, it is the intent of the General
12 Assembly that the Illinois Department implement a
13 reimbursement system for ambulance services that, to the
14 extent practicable and subject to the availability of funds
15 appropriated by the General Assembly for this purpose, is
16 consistent with the payment principles of Medicare. To ensure
17 uniformity between the payment principles of Medicare and
18 Medicaid, the Illinois Department shall follow, to the extent
19 necessary and practicable and subject to the availability of
20 funds appropriated by the General Assembly for this purpose,
21 the statutes, laws, regulations, policies, procedures,
22 principles, definitions, guidelines, and manuals used to
23 determine the amounts paid to ambulance service providers
24 under Title XVIII of the Social Security Act (Medicare).

25 (b) For ambulance services provided to a recipient of aid
26 under this Article on or after January 1, 1996, the Illinois

1 Department shall reimburse ambulance service providers based
2 upon the actual distance traveled if a natural disaster,
3 weather conditions, road repairs, or traffic congestion
4 necessitates the use of a route other than the most direct
5 route.

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

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

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

24 (c-3) For purposes of this Section, "medi-car" means
25 transportation services provided to a patient who is confined
26 to a wheelchair and requires the use of a hydraulic or electric

1 lift or ramp and wheelchair lockdown when the patient's
2 condition does not require medical observation, medical
3 supervision, medical equipment, the administration of
4 medications, or the administration of oxygen.

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

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

12 (e) Beginning with services rendered on or after July 1,
13 2008, all providers of non-emergency medi-car and service car
14 transportation must certify that the driver and employee
15 attendant, as applicable, have completed a safety program
16 approved by the Department to protect both the patient and the
17 driver, prior to transporting a patient. The provider must
18 maintain this certification in its records. The provider shall
19 produce such documentation upon demand by the Department or
20 its representative. Failure to produce documentation of such
21 training shall result in recovery of any payments made by the
22 Department for services rendered by a non-certified driver or
23 employee attendant. Medi-car and service car providers must
24 maintain legible documentation in their records of the driver
25 and, as applicable, employee attendant that actually
26 transported the patient. Providers must recertify all drivers

1 and employee attendants every 3 years. If they meet the
2 established training components set forth by the Department,
3 providers of non-emergency medi-car and service car
4 transportation that are either directly or through an
5 affiliated company licensed by the Department of Public Health
6 shall be approved by the Department to have in-house safety
7 programs for training their own staff.

8 Notwithstanding the requirements above, any public
9 transportation provider of medi-car and service car
10 transportation that receives federal funding under 49 U.S.C.
11 5307 and 5311 need not certify its drivers and employee
12 attendants under this Section, since safety training is
13 already federally mandated.

14 (f) With respect to any policy or program administered by
15 the Department or its agent regarding approval of
16 non-emergency medical transportation by ground ambulance
17 service providers, including, but not limited to, the
18 Non-Emergency Transportation Services Prior Approval Program
19 (NETSPAP), the Department shall establish by rule a process by
20 which ground ambulance service providers of non-emergency
21 medical transportation may appeal any decision by the
22 Department or its agent for which no denial was received prior
23 to the time of transport that either (i) denies a request for
24 approval for payment of non-emergency transportation by means
25 of ground ambulance service or (ii) grants a request for
26 approval of non-emergency transportation by means of ground

1 ambulance service at a level of service that entitles the
2 ground ambulance service provider to a lower level of
3 compensation from the Department than the ground ambulance
4 service provider would have received as compensation for the
5 level of service requested. The rule shall be filed by
6 December 15, 2012 and shall provide that, for any decision
7 rendered by the Department or its agent on or after the date
8 the rule takes effect, the ground ambulance service provider
9 shall have 60 days from the date the decision is received to
10 file an appeal. The rule established by the Department shall
11 be, insofar as is practical, consistent with the Illinois
12 Administrative Procedure Act. The Director's decision on an
13 appeal under this Section shall be a final administrative
14 decision subject to review under the Administrative Review
15 Law.

16 (f-5) Beginning 90 days after July 20, 2012 (the effective
17 date of Public Act 97-842), (i) no denial of a request for
18 approval for payment of non-emergency transportation by means
19 of ground ambulance service, and (ii) no approval of
20 non-emergency transportation by means of ground ambulance
21 service at a level of service that entitles the ground
22 ambulance service provider to a lower level of compensation
23 from the Department than would have been received at the level
24 of service submitted by the ground ambulance service provider,
25 may be issued by the Department or its agent unless the
26 Department has submitted the criteria for determining the

1 appropriateness of the transport for first notice publication
2 in the Illinois Register pursuant to Section 5-40 of the
3 Illinois Administrative Procedure Act.

4 (f-6) Within 90 days after the effective date of this
5 amendatory Act of the 102nd General Assembly and subject to
6 federal approval, the Department shall file rules to allow for
7 the approval of ground ambulance services when the sole
8 purpose of the transport is for the navigation of stairs or the
9 assisting or lifting of a patient at a medical facility or
10 during a medical appointment in instances where the Department
11 or a contracted Medicaid managed care organization or their
12 transportation broker is unable to secure transportation
13 through any other transportation provider.

14 (f-7) For non-emergency ground ambulance claims properly
15 denied under Department policy at the time the claim is filed
16 due to failure to submit a valid Medical Certification for
17 Non-Emergency Ambulance on and after December 15, 2012 and
18 prior to January 1, 2021, the Department shall allot
19 \$2,000,000 to a pool to reimburse such claims if the provider
20 proves medical necessity for the service by other means.
21 Providers must submit any such denied claims for which they
22 seek compensation to the Department no later than December 31,
23 2021 along with documentation of medical necessity. No later
24 than May 31, 2022, the Department shall determine for which
25 claims medical necessity was established. Such claims for
26 which medical necessity was established shall be paid at the

1 rate in effect at the time of the service, provided the
2 \$2,000,000 is sufficient to pay at those rates. If the pool is
3 not sufficient, claims shall be paid at a uniform percentage
4 of the applicable rate such that the pool of \$2,000,000 is
5 exhausted. The appeal process described in subsection (f)
6 shall not be applicable to the Department's determinations
7 made in accordance with this subsection.

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

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

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

1 stakeholders. The Physician Certification Statement shall
2 include, but is not limited to, the criteria necessary to
3 demonstrate medical necessity for the level of transport
4 needed as required by (i) the Department of Healthcare and
5 Family Services and (ii) the federal Centers for Medicare and
6 Medicaid Services as outlined in the Centers for Medicare and
7 Medicaid Services' Medicare Benefit Policy Manual, Pub.
8 100-02, Chap. 10, Sec. 10.2.1, et seq. The use of the Physician
9 Certification Statement shall satisfy the obligations of
10 hospitals under Section 6.22 of the Hospital Licensing Act and
11 nursing homes under Section 2-217 of the Nursing Home Care
12 Act. Implementation and acceptance of the Physician
13 Certification Statement shall take place no later than 90 days
14 after the issuance of the Physician Certification Statement by
15 the Department of Healthcare and Family Services.

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

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

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

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

11 (i) Subject to federal approval, ~~On and after July 1,~~
12 ~~2018,~~ the Department shall increase the base rate of
13 reimbursement for both base charges and mileage charges for
14 ground ambulance service providers not participating in the
15 Ground Emergency Medical Transportation (GEMT) Program for
16 medical transportation services provided by means of a ground
17 ambulance to a level not lower than 140% ~~112%~~ of the base rate
18 in effect as of January 1, 2023 ~~June 30, 2018~~.

19 (j) For the purpose of understanding ground ambulance
20 transportation services cost structures and their impact on
21 the Medical Assistance Program, the Department shall engage
22 stakeholders, including, but not limited to, a statewide
23 association representing private ground ambulance service
24 providers in Illinois, to develop recommendations for a plan
25 for the regular collection of cost data for all ground
26 ambulance transportation providers reimbursed under the

1 Illinois Title XIX State Plan. Cost data obtained through this
2 process shall be used to inform on and to ensure the
3 effectiveness and efficiency of Illinois Medicaid rates. The
4 Department shall establish a process to limit public
5 availability of portions of the cost report data determined to
6 be proprietary. This process shall be concluded and
7 recommendations shall be provided no later than April 1, 2024.

8 (Source: P.A. 101-81, eff. 7-12-19; 101-649, eff. 7-7-20;
9 102-364, eff. 1-1-22; 102-650, eff. 8-27-21; 102-813, eff.
10 5-13-22; 102-1037, eff. 6-2-22.)

11 ARTICLE 85.

12 Section 85-5. The Illinois Act on the Aging is amended by
13 changing Sections 4.02 and 4.06 as follows:

14 (20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

15 Sec. 4.02. Community Care Program. The Department shall
16 establish a program of services to prevent unnecessary
17 institutionalization of persons age 60 and older in need of
18 long term care or who are established as persons who suffer
19 from Alzheimer's disease or a related disorder under the
20 Alzheimer's Disease Assistance Act, thereby enabling them to
21 remain in their own homes or in other living arrangements.
22 Such preventive services, which may be coordinated with other
23 programs for the aged and monitored by area agencies on aging

1 in cooperation with the Department, may include, but are not
2 limited to, any or all of the following:

3 (a) (blank);

4 (b) (blank);

5 (c) home care aide services;

6 (d) personal assistant services;

7 (e) adult day services;

8 (f) home-delivered meals;

9 (g) education in self-care;

10 (h) personal care services;

11 (i) adult day health services;

12 (j) habilitation services;

13 (k) respite care;

14 (k-5) community reintegration services;

15 (k-6) flexible senior services;

16 (k-7) medication management;

17 (k-8) emergency home response;

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

20 (m) clearinghouse for information provided by senior
21 citizen home owners who want to rent rooms to or share
22 living space with other senior citizens.

23 The Department shall establish eligibility standards for
24 such services. In determining the amount and nature of
25 services for which a person may qualify, consideration shall
26 not be given to the value of cash, property or other assets

1 held in the name of the person's spouse pursuant to a written
2 agreement dividing marital property into equal but separate
3 shares or pursuant to a transfer of the person's interest in a
4 home to his spouse, provided that the spouse's share of the
5 marital property is not made available to the person seeking
6 such services.

7 Beginning January 1, 2008, the Department shall require as
8 a condition of eligibility that all new financially eligible
9 applicants apply for and enroll in medical assistance under
10 Article V of the Illinois Public Aid Code in accordance with
11 rules promulgated by the Department.

12 The Department shall, in conjunction with the Department
13 of Public Aid (now Department of Healthcare and Family
14 Services), seek appropriate amendments under Sections 1915 and
15 1924 of the Social Security Act. The purpose of the amendments
16 shall be to extend eligibility for home and community based
17 services under Sections 1915 and 1924 of the Social Security
18 Act to persons who transfer to or for the benefit of a spouse
19 those amounts of income and resources allowed under Section
20 1924 of the Social Security Act. Subject to the approval of
21 such amendments, the Department shall extend the provisions of
22 Section 5-4 of the Illinois Public Aid Code to persons who, but
23 for the provision of home or community-based services, would
24 require the level of care provided in an institution, as is
25 provided for in federal law. Those persons no longer found to
26 be eligible for receiving noninstitutional services due to

1 changes in the eligibility criteria shall be given 45 days
2 notice prior to actual termination. Those persons receiving
3 notice of termination may contact the Department and request
4 the determination be appealed at any time during the 45 day
5 notice period. The target population identified for the
6 purposes of this Section are persons age 60 and older with an
7 identified service need. Priority shall be given to those who
8 are at imminent risk of institutionalization. The services
9 shall be provided to eligible persons age 60 and older to the
10 extent that the cost of the services together with the other
11 personal maintenance expenses of the persons are reasonably
12 related to the standards established for care in a group
13 facility appropriate to the person's condition. These
14 non-institutional services, pilot projects or experimental
15 facilities may be provided as part of or in addition to those
16 authorized by federal law or those funded and administered by
17 the Department of Human Services. The Departments of Human
18 Services, Healthcare and Family Services, Public Health,
19 Veterans' Affairs, and Commerce and Economic Opportunity and
20 other appropriate agencies of State, federal and local
21 governments shall cooperate with the Department on Aging in
22 the establishment and development of the non-institutional
23 services. The Department shall require an annual audit from
24 all personal assistant and home care aide vendors contracting
25 with the Department under this Section. The annual audit shall
26 assure that each audited vendor's procedures are in compliance

1 with Department's financial reporting guidelines requiring an
2 administrative and employee wage and benefits cost split as
3 defined in administrative rules. The audit is a public record
4 under the Freedom of Information Act. The Department shall
5 execute, relative to the nursing home prescreening project,
6 written inter-agency agreements with the Department of Human
7 Services and the Department of Healthcare and Family Services,
8 to effect the following: (1) intake procedures and common
9 eligibility criteria for those persons who are receiving
10 non-institutional services; and (2) the establishment and
11 development of non-institutional services in areas of the
12 State where they are not currently available or are
13 undeveloped. On and after July 1, 1996, all nursing home
14 prescreenings for individuals 60 years of age or older shall
15 be conducted by the Department.

16 As part of the Department on Aging's routine training of
17 case managers and case manager supervisors, the Department may
18 include information on family futures planning for persons who
19 are age 60 or older and who are caregivers of their adult
20 children with developmental disabilities. The content of the
21 training shall be at the Department's discretion.

22 The Department is authorized to establish a system of
23 recipient copayment for services provided under this Section,
24 such copayment to be based upon the recipient's ability to pay
25 but in no case to exceed the actual cost of the services
26 provided. Additionally, any portion of a person's income which

1 is equal to or less than the federal poverty standard shall not
2 be considered by the Department in determining the copayment.
3 The level of such copayment shall be adjusted whenever
4 necessary to reflect any change in the officially designated
5 federal poverty standard.

6 The Department, or the Department's authorized
7 representative, may recover the amount of moneys expended for
8 services provided to or in behalf of a person under this
9 Section by a claim against the person's estate or against the
10 estate of the person's surviving spouse, but no recovery may
11 be had until after the death of the surviving spouse, if any,
12 and then only at such time when there is no surviving child who
13 is under age 21 or blind or who has a permanent and total
14 disability. This paragraph, however, shall not bar recovery,
15 at the death of the person, of moneys for services provided to
16 the person or in behalf of the person under this Section to
17 which the person was not entitled; provided that such recovery
18 shall not be enforced against any real estate while it is
19 occupied as a homestead by the surviving spouse or other
20 dependent, if no claims by other creditors have been filed
21 against the estate, or, if such claims have been filed, they
22 remain dormant for failure of prosecution or failure of the
23 claimant to compel administration of the estate for the
24 purpose of payment. This paragraph shall not bar recovery from
25 the estate of a spouse, under Sections 1915 and 1924 of the
26 Social Security Act and Section 5-4 of the Illinois Public Aid

1 Code, who precedes a person receiving services under this
2 Section in death. All moneys for services paid to or in behalf
3 of the person under this Section shall be claimed for recovery
4 from the deceased spouse's estate. "Homestead", as used in
5 this paragraph, means the dwelling house and contiguous real
6 estate occupied by a surviving spouse or relative, as defined
7 by the rules and regulations of the Department of Healthcare
8 and Family Services, regardless of the value of the property.

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

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

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

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

25 (4) ensuring that the determination of need tool is
26 accurate in determining the participants' level of need;

1 to achieve this, the Department, in conjunction with the
2 Older Adult Services Advisory Committee, shall institute a
3 study of the relationship between the Determination of
4 Need scores, level of need, service cost maximums, and the
5 development and utilization of service plans no later than
6 May 1, 2008; findings and recommendations shall be
7 presented to the Governor and the General Assembly no
8 later than January 1, 2009; recommendations shall include
9 all needed changes to the service cost maximums schedule
10 and additional covered services;

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

- 14 (A) bathing;
- 15 (B) grooming;
- 16 (C) toileting;
- 17 (D) nail care;
- 18 (E) transferring;
- 19 (F) respiratory services;
- 20 (G) exercise; or
- 21 (H) positioning;

22 (6) ensuring that homemaker program vendors are not
23 restricted from hiring homemakers who are family members
24 of clients or recommended by clients; the Department may
25 not, by rule or policy, require homemakers who are family
26 members of clients or recommended by clients to accept

1 assignments in homes other than the client;

2 (7) ensuring that the State may access maximum federal
3 matching funds by seeking approval for the Centers for
4 Medicare and Medicaid Services for modifications to the
5 State's home and community based services waiver and
6 additional waiver opportunities, including applying for
7 enrollment in the Balance Incentive Payment Program by May
8 1, 2013, in order to maximize federal matching funds; this
9 shall include, but not be limited to, modification that
10 reflects all changes in the Community Care Program
11 services and all increases in the services cost maximum;

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

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

24 (10) working in conjunction with Care Coordination
25 Units, the Department of Healthcare and Family Services,
26 the Department of Human Services, Community Care Program

1 providers, and other stakeholders to make improvements to
2 the Medicaid claiming processes and the Medicaid
3 enrollment procedures or requirements as needed,
4 including, but not limited to, specific policy changes or
5 rules to improve the up-front enrollment of participants
6 in the Medicaid program and specific policy changes or
7 rules to insure more prompt submission of bills to the
8 federal government to secure maximum federal matching
9 dollars as promptly as possible; the Department on Aging
10 shall have at least 3 meetings with stakeholders by
11 January 1, 2014 in order to address these improvements;

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

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

23 (13) maintaining fiscal year 2014 rates at the same
24 level established on January 1, 2013.

25 By January 1, 2009 or as soon after the end of the Cash and
26 Counseling Demonstration Project as is practicable, the

1 Department may, based on its evaluation of the demonstration
2 project, promulgate rules concerning personal assistant
3 services, to include, but need not be limited to,
4 qualifications, employment screening, rights under fair labor
5 standards, training, fiduciary agent, and supervision
6 requirements. All applicants shall be subject to the
7 provisions of the Health Care Worker Background Check Act.

8 The Department shall develop procedures to enhance
9 availability of services on evenings, weekends, and on an
10 emergency basis to meet the respite needs of caregivers.
11 Procedures shall be developed to permit the utilization of
12 services in successive blocks of 24 hours up to the monthly
13 maximum established by the Department. Workers providing these
14 services shall be appropriately trained.

15 Beginning on the effective date of this amendatory Act of
16 1991, no person may perform chore/housekeeping and home care
17 aide services under a program authorized by this Section
18 unless that person has been issued a certificate of
19 pre-service to do so by his or her employing agency.
20 Information gathered to effect such certification shall
21 include (i) the person's name, (ii) the date the person was
22 hired by his or her current employer, and (iii) the training,
23 including dates and levels. Persons engaged in the program
24 authorized by this Section before the effective date of this
25 amendatory Act of 1991 shall be issued a certificate of all
26 pre- and in-service training from his or her employer upon

1 submitting the necessary information. The employing agency
2 shall be required to retain records of all staff pre- and
3 in-service training, and shall provide such records to the
4 Department upon request and upon termination of the employer's
5 contract with the Department. In addition, the employing
6 agency is responsible for the issuance of certifications of
7 in-service training completed to their employees.

8 The Department is required to develop a system to ensure
9 that persons working as home care aides and personal
10 assistants receive increases in their wages when the federal
11 minimum wage is increased by requiring vendors to certify that
12 they are meeting the federal minimum wage statute for home
13 care aides and personal assistants. An employer that cannot
14 ensure that the minimum wage increase is being given to home
15 care aides and personal assistants shall be denied any
16 increase in reimbursement costs.

17 The Community Care Program Advisory Committee is created
18 in the Department on Aging. The Director shall appoint
19 individuals to serve in the Committee, who shall serve at
20 their own expense. Members of the Committee must abide by all
21 applicable ethics laws. The Committee shall advise the
22 Department on issues related to the Department's program of
23 services to prevent unnecessary institutionalization. The
24 Committee shall meet on a bi-monthly basis and shall serve to
25 identify and advise the Department on present and potential
26 issues affecting the service delivery network, the program's

1 clients, and the Department and to recommend solution
2 strategies. Persons appointed to the Committee shall be
3 appointed on, but not limited to, their own and their agency's
4 experience with the program, geographic representation, and
5 willingness to serve. The Director shall appoint members to
6 the Committee to represent provider, advocacy, policy
7 research, and other constituencies committed to the delivery
8 of high quality home and community-based services to older
9 adults. Representatives shall be appointed to ensure
10 representation from community care providers including, but
11 not limited to, adult day service providers, homemaker
12 providers, case coordination and case management units,
13 emergency home response providers, statewide trade or labor
14 unions that represent home care aides and direct care staff,
15 area agencies on aging, adults over age 60, membership
16 organizations representing older adults, and other
17 organizational entities, providers of care, or individuals
18 with demonstrated interest and expertise in the field of home
19 and community care as determined by the Director.

20 Nominations may be presented from any agency or State
21 association with interest in the program. The Director, or his
22 or her designee, shall serve as the permanent co-chair of the
23 advisory committee. One other co-chair shall be nominated and
24 approved by the members of the committee on an annual basis.
25 Committee members' terms of appointment shall be for 4 years
26 with one-quarter of the appointees' terms expiring each year.

1 A member shall continue to serve until his or her replacement
2 is named. The Department shall fill vacancies that have a
3 remaining term of over one year, and this replacement shall
4 occur through the annual replacement of expiring terms. The
5 Director shall designate Department staff to provide technical
6 assistance and staff support to the committee. Department
7 representation shall not constitute membership of the
8 committee. All Committee papers, issues, recommendations,
9 reports, and meeting memoranda are advisory only. The
10 Director, or his or her designee, shall make a written report,
11 as requested by the Committee, regarding issues before the
12 Committee.

13 The Department on Aging and the Department of Human
14 Services shall cooperate in the development and submission of
15 an annual report on programs and services provided under this
16 Section. Such joint report shall be filed with the Governor
17 and the General Assembly on or before September 30 each year.

18 The requirement for reporting to the General Assembly
19 shall be satisfied by filing copies of the report as required
20 by Section 3.1 of the General Assembly Organization Act and
21 filing such additional copies with the State Government Report
22 Distribution Center for the General Assembly as is required
23 under paragraph (t) of Section 7 of the State Library Act.

24 Those persons previously found eligible for receiving
25 non-institutional services whose services were discontinued
26 under the Emergency Budget Act of Fiscal Year 1992, and who do

1 not meet the eligibility standards in effect on or after July
2 1, 1992, shall remain ineligible on and after July 1, 1992.
3 Those persons previously not required to cost-share and who
4 were required to cost-share effective March 1, 1992, shall
5 continue to meet cost-share requirements on and after July 1,
6 1992. Beginning July 1, 1992, all clients will be required to
7 meet eligibility, cost-share, and other requirements and will
8 have services discontinued or altered when they fail to meet
9 these requirements.

10 For the purposes of this Section, "flexible senior
11 services" refers to services that require one-time or periodic
12 expenditures including, but not limited to, respite care, home
13 modification, assistive technology, housing assistance, and
14 transportation.

15 The Department shall implement an electronic service
16 verification based on global positioning systems or other
17 cost-effective technology for the Community Care Program no
18 later than January 1, 2014.

19 The Department shall require, as a condition of
20 eligibility, enrollment in the medical assistance program
21 under Article V of the Illinois Public Aid Code (i) beginning
22 August 1, 2013, if the Auditor General has reported that the
23 Department has failed to comply with the reporting
24 requirements of Section 2-27 of the Illinois State Auditing
25 Act; or (ii) beginning June 1, 2014, if the Auditor General has
26 reported that the Department has not undertaken the required

1 actions listed in the report required by subsection (a) of
2 Section 2-27 of the Illinois State Auditing Act.

3 The Department shall delay Community Care Program services
4 until an applicant is determined eligible for medical
5 assistance under Article V of the Illinois Public Aid Code (i)
6 beginning August 1, 2013, if the Auditor General has reported
7 that the Department has failed to comply with the reporting
8 requirements of Section 2-27 of the Illinois State Auditing
9 Act; or (ii) beginning June 1, 2014, if the Auditor General has
10 reported that the Department has not undertaken the required
11 actions listed in the report required by subsection (a) of
12 Section 2-27 of the Illinois State Auditing Act.

13 The Department shall implement co-payments for the
14 Community Care Program at the federally allowable maximum
15 level (i) beginning August 1, 2013, if the Auditor General has
16 reported that the Department has failed to comply with the
17 reporting requirements of Section 2-27 of the Illinois State
18 Auditing Act; or (ii) beginning June 1, 2014, if the Auditor
19 General has reported that the Department has not undertaken
20 the required actions listed in the report required by
21 subsection (a) of Section 2-27 of the Illinois State Auditing
22 Act.

23 The Department shall continue to provide other Community
24 Care Program reports as required by statute.

25 The Department shall conduct a quarterly review of Care
26 Coordination Unit performance and adherence to service

1 guidelines. The quarterly review shall be reported to the
2 Speaker of the House of Representatives, the Minority Leader
3 of the House of Representatives, the President of the Senate,
4 and the Minority Leader of the Senate. The Department shall
5 collect and report longitudinal data on the performance of
6 each care coordination unit. Nothing in this paragraph shall
7 be construed to require the Department to identify specific
8 care coordination units.

9 In regard to community care providers, failure to comply
10 with Department on Aging policies shall be cause for
11 disciplinary action, including, but not limited to,
12 disqualification from serving Community Care Program clients.
13 Each provider, upon submission of any bill or invoice to the
14 Department for payment for services rendered, shall include a
15 notarized statement, under penalty of perjury pursuant to
16 Section 1-109 of the Code of Civil Procedure, that the
17 provider has complied with all Department policies.

18 The Director of the Department on Aging shall make
19 information available to the State Board of Elections as may
20 be required by an agreement the State Board of Elections has
21 entered into with a multi-state voter registration list
22 maintenance system.

23 Within 30 days after July 6, 2017 (the effective date of
24 Public Act 100-23), rates shall be increased to \$18.29 per
25 hour, for the purpose of increasing, by at least \$.72 per hour,
26 the wages paid by those vendors to their employees who provide

1 homemaker services. The Department shall pay an enhanced rate
2 under the Community Care Program to those in-home service
3 provider agencies that offer health insurance coverage as a
4 benefit to their direct service worker employees consistent
5 with the mandates of Public Act 95-713. For State fiscal years
6 2018 and 2019, the enhanced rate shall be \$1.77 per hour. The
7 rate shall be adjusted using actuarial analysis based on the
8 cost of care, but shall not be set below \$1.77 per hour. The
9 Department shall adopt rules, including emergency rules under
10 subsections (y) and (bb) of Section 5-45 of the Illinois
11 Administrative Procedure Act, to implement the provisions of
12 this paragraph.

13 Subject to federal approval, rates for adult day services
14 shall be increased to \$16.84 per hour and rates for each way
15 transportation services for adult day services shall be
16 increased to \$12.44 per unit transportation.

17 The General Assembly finds it necessary to authorize an
18 aggressive Medicaid enrollment initiative designed to maximize
19 federal Medicaid funding for the Community Care Program which
20 produces significant savings for the State of Illinois. The
21 Department on Aging shall establish and implement a Community
22 Care Program Medicaid Initiative. Under the Initiative, the
23 Department on Aging shall, at a minimum: (i) provide an
24 enhanced rate to adequately compensate care coordination units
25 to enroll eligible Community Care Program clients into
26 Medicaid; (ii) use recommendations from a stakeholder

1 committee on how best to implement the Initiative; and (iii)
2 establish requirements for State agencies to make enrollment
3 in the State's Medical Assistance program easier for seniors.

4 The Community Care Program Medicaid Enrollment Oversight
5 Subcommittee is created as a subcommittee of the Older Adult
6 Services Advisory Committee established in Section 35 of the
7 Older Adult Services Act to make recommendations on how best
8 to increase the number of medical assistance recipients who
9 are enrolled in the Community Care Program. The Subcommittee
10 shall consist of all of the following persons who must be
11 appointed within 30 days after the effective date of this
12 amendatory Act of the 100th General Assembly:

13 (1) The Director of Aging, or his or her designee, who
14 shall serve as the chairperson of the Subcommittee.

15 (2) One representative of the Department of Healthcare
16 and Family Services, appointed by the Director of
17 Healthcare and Family Services.

18 (3) One representative of the Department of Human
19 Services, appointed by the Secretary of Human Services.

20 (4) One individual representing a care coordination
21 unit, appointed by the Director of Aging.

22 (5) One individual from a non-governmental statewide
23 organization that advocates for seniors, appointed by the
24 Director of Aging.

25 (6) One individual representing Area Agencies on
26 Aging, appointed by the Director of Aging.

1 (7) One individual from a statewide association
2 dedicated to Alzheimer's care, support, and research,
3 appointed by the Director of Aging.

4 (8) One individual from an organization that employs
5 persons who provide services under the Community Care
6 Program, appointed by the Director of Aging.

7 (9) One member of a trade or labor union representing
8 persons who provide services under the Community Care
9 Program, appointed by the Director of Aging.

10 (10) One member of the Senate, who shall serve as
11 co-chairperson, appointed by the President of the Senate.

12 (11) One member of the Senate, who shall serve as
13 co-chairperson, appointed by the Minority Leader of the
14 Senate.

15 (12) One member of the House of Representatives, who
16 shall serve as co-chairperson, appointed by the Speaker of
17 the House of Representatives.

18 (13) One member of the House of Representatives, who
19 shall serve as co-chairperson, appointed by the Minority
20 Leader of the House of Representatives.

21 (14) One individual appointed by a labor organization
22 representing frontline employees at the Department of
23 Human Services.

24 The Subcommittee shall provide oversight to the Community
25 Care Program Medicaid Initiative and shall meet quarterly. At
26 each Subcommittee meeting the Department on Aging shall

1 provide the following data sets to the Subcommittee: (A) the
2 number of Illinois residents, categorized by planning and
3 service area, who are receiving services under the Community
4 Care Program and are enrolled in the State's Medical
5 Assistance Program; (B) the number of Illinois residents,
6 categorized by planning and service area, who are receiving
7 services under the Community Care Program, but are not
8 enrolled in the State's Medical Assistance Program; and (C)
9 the number of Illinois residents, categorized by planning and
10 service area, who are receiving services under the Community
11 Care Program and are eligible for benefits under the State's
12 Medical Assistance Program, but are not enrolled in the
13 State's Medical Assistance Program. In addition to this data,
14 the Department on Aging shall provide the Subcommittee with
15 plans on how the Department on Aging will reduce the number of
16 Illinois residents who are not enrolled in the State's Medical
17 Assistance Program but who are eligible for medical assistance
18 benefits. The Department on Aging shall enroll in the State's
19 Medical Assistance Program those Illinois residents who
20 receive services under the Community Care Program and are
21 eligible for medical assistance benefits but are not enrolled
22 in the State's Medicaid Assistance Program. The data provided
23 to the Subcommittee shall be made available to the public via
24 the Department on Aging's website.

25 The Department on Aging, with the involvement of the
26 Subcommittee, shall collaborate with the Department of Human

1 Services and the Department of Healthcare and Family Services
2 on how best to achieve the responsibilities of the Community
3 Care Program Medicaid Initiative.

4 The Department on Aging, the Department of Human Services,
5 and the Department of Healthcare and Family Services shall
6 coordinate and implement a streamlined process for seniors to
7 access benefits under the State's Medical Assistance Program.

8 The Subcommittee shall collaborate with the Department of
9 Human Services on the adoption of a uniform application
10 submission process. The Department of Human Services and any
11 other State agency involved with processing the medical
12 assistance application of any person enrolled in the Community
13 Care Program shall include the appropriate care coordination
14 unit in all communications related to the determination or
15 status of the application.

16 The Community Care Program Medicaid Initiative shall
17 provide targeted funding to care coordination units to help
18 seniors complete their applications for medical assistance
19 benefits. On and after July 1, 2019, care coordination units
20 shall receive no less than \$200 per completed application,
21 which rate may be included in a bundled rate for initial intake
22 services when Medicaid application assistance is provided in
23 conjunction with the initial intake process for new program
24 participants.

25 The Community Care Program Medicaid Initiative shall cease
26 operation 5 years after the effective date of this amendatory

1 Act of the 100th General Assembly, after which the
2 Subcommittee shall dissolve.

3 (Source: P.A. 101-10, eff. 6-5-19; 102-1071, eff. 6-10-22.)

4 (20 ILCS 105/4.06)

5 Sec. 4.06. Coordinated services for minority senior
6 citizens ~~Minority Senior Citizen Program~~. The Department shall
7 develop strategies ~~a program~~ to identify the special needs and
8 problems of minority senior citizens and evaluate the adequacy
9 and accessibility of existing services ~~programs~~ and
10 information for minority senior citizens. The Department shall
11 coordinate services for minority senior citizens through the
12 Department of Public Health, the Department of Healthcare and
13 Family Services, and the Department of Human Services.

14 The Department shall develop procedures to enhance and
15 identify availability of services and shall promulgate
16 administrative rules to establish the responsibilities of the
17 Department.

18 The Department on Aging, the Department of Public Health,
19 the Department of Healthcare and Family Services, and the
20 Department of Human Services shall cooperate in the
21 development and submission of an annual report on ~~programs and~~
22 services provided under this Section. The joint report shall
23 be filed with the Governor and the General Assembly on or
24 before September 30 of each year.

25 (Source: P.A. 95-331, eff. 8-21-07.)

- 1 (i) adult day health services;
- 2 (j) habilitation services;
- 3 (k) respite care;
- 4 (k-5) community reintegration services;
- 5 (k-6) flexible senior services;
- 6 (k-7) medication management;
- 7 (k-8) emergency home response;
- 8 (l) other nonmedical social services that may enable
- 9 the person to become self-supporting; or
- 10 (m) clearinghouse for information provided by senior
- 11 citizen home owners who want to rent rooms to or share
- 12 living space with other senior citizens.

13 The Department shall establish eligibility standards for

14 such services. In determining the amount and nature of

15 services for which a person may qualify, consideration shall

16 not be given to the value of cash, property or other assets

17 held in the name of the person's spouse pursuant to a written

18 agreement dividing marital property into equal but separate

19 shares or pursuant to a transfer of the person's interest in a

20 home to his spouse, provided that the spouse's share of the

21 marital property is not made available to the person seeking

22 such services.

23 Beginning January 1, 2008, the Department shall require as

24 a condition of eligibility that all new financially eligible

25 applicants apply for and enroll in medical assistance under

26 Article V of the Illinois Public Aid Code in accordance with

1 rules promulgated by the Department.

2 The Department shall, in conjunction with the Department
3 of Public Aid (now Department of Healthcare and Family
4 Services), seek appropriate amendments under Sections 1915 and
5 1924 of the Social Security Act. The purpose of the amendments
6 shall be to extend eligibility for home and community based
7 services under Sections 1915 and 1924 of the Social Security
8 Act to persons who transfer to or for the benefit of a spouse
9 those amounts of income and resources allowed under Section
10 1924 of the Social Security Act. Subject to the approval of
11 such amendments, the Department shall extend the provisions of
12 Section 5-4 of the Illinois Public Aid Code to persons who, but
13 for the provision of home or community-based services, would
14 require the level of care provided in an institution, as is
15 provided for in federal law. Those persons no longer found to
16 be eligible for receiving noninstitutional services due to
17 changes in the eligibility criteria shall be given 45 days
18 notice prior to actual termination. Those persons receiving
19 notice of termination may contact the Department and request
20 the determination be appealed at any time during the 45 day
21 notice period. The target population identified for the
22 purposes of this Section are persons age 60 and older with an
23 identified service need. Priority shall be given to those who
24 are at imminent risk of institutionalization. The services
25 shall be provided to eligible persons age 60 and older to the
26 extent that the cost of the services together with the other

1 personal maintenance expenses of the persons are reasonably
2 related to the standards established for care in a group
3 facility appropriate to the person's condition. These
4 non-institutional services, pilot projects or experimental
5 facilities may be provided as part of or in addition to those
6 authorized by federal law or those funded and administered by
7 the Department of Human Services. The Departments of Human
8 Services, Healthcare and Family Services, Public Health,
9 Veterans' Affairs, and Commerce and Economic Opportunity and
10 other appropriate agencies of State, federal and local
11 governments shall cooperate with the Department on Aging in
12 the establishment and development of the non-institutional
13 services. The Department shall require an annual audit from
14 all personal assistant and home care aide vendors contracting
15 with the Department under this Section. The annual audit shall
16 assure that each audited vendor's procedures are in compliance
17 with Department's financial reporting guidelines requiring an
18 administrative and employee wage and benefits cost split as
19 defined in administrative rules. The audit is a public record
20 under the Freedom of Information Act. The Department shall
21 execute, relative to the nursing home prescreening project,
22 written inter-agency agreements with the Department of Human
23 Services and the Department of Healthcare and Family Services,
24 to effect the following: (1) intake procedures and common
25 eligibility criteria for those persons who are receiving
26 non-institutional services; and (2) the establishment and

1 development of non-institutional services in areas of the
2 State where they are not currently available or are
3 undeveloped. On and after July 1, 1996, all nursing home
4 prescreenings for individuals 60 years of age or older shall
5 be conducted by the Department.

6 As part of the Department on Aging's routine training of
7 case managers and case manager supervisors, the Department may
8 include information on family futures planning for persons who
9 are age 60 or older and who are caregivers of their adult
10 children with developmental disabilities. The content of the
11 training shall be at the Department's discretion.

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

22 The Department, or the Department's authorized
23 representative, may recover the amount of moneys expended for
24 services provided to or in behalf of a person under this
25 Section by a claim against the person's estate or against the
26 estate of the person's surviving spouse, but no recovery may

1 be had until after the death of the surviving spouse, if any,
2 and then only at such time when there is no surviving child who
3 is under age 21 or blind or who has a permanent and total
4 disability. This paragraph, however, shall not bar recovery,
5 at the death of the person, of moneys for services provided to
6 the person or in behalf of the person under this Section to
7 which the person was not entitled; provided that such recovery
8 shall not be enforced against any real estate while it is
9 occupied as a homestead by the surviving spouse or other
10 dependent, if no claims by other creditors have been filed
11 against the estate, or, if such claims have been filed, they
12 remain dormant for failure of prosecution or failure of the
13 claimant to compel administration of the estate for the
14 purpose of payment. This paragraph shall not bar recovery from
15 the estate of a spouse, under Sections 1915 and 1924 of the
16 Social Security Act and Section 5-4 of the Illinois Public Aid
17 Code, who precedes a person receiving services under this
18 Section in death. All moneys for services paid to or in behalf
19 of the person under this Section shall be claimed for recovery
20 from the deceased spouse's estate. "Homestead", as used in
21 this paragraph, means the dwelling house and contiguous real
22 estate occupied by a surviving spouse or relative, as defined
23 by the rules and regulations of the Department of Healthcare
24 and Family Services, regardless of the value of the property.

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

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

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

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

15 (4) ensuring that the determination of need tool is
16 accurate in determining the participants' level of need;
17 to achieve this, the Department, in conjunction with the
18 Older Adult Services Advisory Committee, shall institute a
19 study of the relationship between the Determination of
20 Need scores, level of need, service cost maximums, and the
21 development and utilization of service plans no later than
22 May 1, 2008; findings and recommendations shall be
23 presented to the Governor and the General Assembly no
24 later than January 1, 2009; recommendations shall include
25 all needed changes to the service cost maximums schedule
26 and additional covered services;

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

4 (A) bathing;

5 (B) grooming;

6 (C) toileting;

7 (D) nail care;

8 (E) transferring;

9 (F) respiratory services;

10 (G) exercise; or

11 (H) positioning;

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

18 (7) ensuring that the State may access maximum federal
19 matching funds by seeking approval for the Centers for
20 Medicare and Medicaid Services for modifications to the
21 State's home and community based services waiver and
22 additional waiver opportunities, including applying for
23 enrollment in the Balance Incentive Payment Program by May
24 1, 2013, in order to maximize federal matching funds; this
25 shall include, but not be limited to, modification that
26 reflects all changes in the Community Care Program

1 services and all increases in the services cost maximum;

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

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

14 (10) working in conjunction with Care Coordination
15 Units, the Department of Healthcare and Family Services,
16 the Department of Human Services, Community Care Program
17 providers, and other stakeholders to make improvements to
18 the Medicaid claiming processes and the Medicaid
19 enrollment procedures or requirements as needed,
20 including, but not limited to, specific policy changes or
21 rules to improve the up-front enrollment of participants
22 in the Medicaid program and specific policy changes or
23 rules to insure more prompt submission of bills to the
24 federal government to secure maximum federal matching
25 dollars as promptly as possible; the Department on Aging
26 shall have at least 3 meetings with stakeholders by

1 January 1, 2014 in order to address these improvements;

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

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

13 (13) maintaining fiscal year 2014 rates at the same
14 level established on January 1, 2013.

15 By January 1, 2009 or as soon after the end of the Cash and
16 Counseling Demonstration Project as is practicable, the
17 Department may, based on its evaluation of the demonstration
18 project, promulgate rules concerning personal assistant
19 services, to include, but need not be limited to,
20 qualifications, employment screening, rights under fair labor
21 standards, training, fiduciary agent, and supervision
22 requirements. All applicants shall be subject to the
23 provisions of the Health Care Worker Background Check Act.

24 The Department shall develop procedures to enhance
25 availability of services on evenings, weekends, and on an
26 emergency basis to meet the respite needs of caregivers.

1 Procedures shall be developed to permit the utilization of
2 services in successive blocks of 24 hours up to the monthly
3 maximum established by the Department. Workers providing these
4 services shall be appropriately trained.

5 Beginning on the effective date of this amendatory Act of
6 1991, no person may perform chore/housekeeping and home care
7 aide services under a program authorized by this Section
8 unless that person has been issued a certificate of
9 pre-service to do so by his or her employing agency.
10 Information gathered to effect such certification shall
11 include (i) the person's name, (ii) the date the person was
12 hired by his or her current employer, and (iii) the training,
13 including dates and levels. Persons engaged in the program
14 authorized by this Section before the effective date of this
15 amendatory Act of 1991 shall be issued a certificate of all
16 pre- and in-service training from his or her employer upon
17 submitting the necessary information. The employing agency
18 shall be required to retain records of all staff pre- and
19 in-service training, and shall provide such records to the
20 Department upon request and upon termination of the employer's
21 contract with the Department. In addition, the employing
22 agency is responsible for the issuance of certifications of
23 in-service training completed to their employees.

24 The Department is required to develop a system to ensure
25 that persons working as home care aides and personal
26 assistants receive increases in their wages when the federal

1 minimum wage is increased by requiring vendors to certify that
2 they are meeting the federal minimum wage statute for home
3 care aides and personal assistants. An employer that cannot
4 ensure that the minimum wage increase is being given to home
5 care aides and personal assistants shall be denied any
6 increase in reimbursement costs.

7 The Community Care Program Advisory Committee is created
8 in the Department on Aging. The Director shall appoint
9 individuals to serve in the Committee, who shall serve at
10 their own expense. Members of the Committee must abide by all
11 applicable ethics laws. The Committee shall advise the
12 Department on issues related to the Department's program of
13 services to prevent unnecessary institutionalization. The
14 Committee shall meet on a bi-monthly basis and shall serve to
15 identify and advise the Department on present and potential
16 issues affecting the service delivery network, the program's
17 clients, and the Department and to recommend solution
18 strategies. Persons appointed to the Committee shall be
19 appointed on, but not limited to, their own and their agency's
20 experience with the program, geographic representation, and
21 willingness to serve. The Director shall appoint members to
22 the Committee to represent provider, advocacy, policy
23 research, and other constituencies committed to the delivery
24 of high quality home and community-based services to older
25 adults. Representatives shall be appointed to ensure
26 representation from community care providers including, but

1 not limited to, adult day service providers, homemaker
2 providers, case coordination and case management units,
3 emergency home response providers, statewide trade or labor
4 unions that represent home care aides and direct care staff,
5 area agencies on aging, adults over age 60, membership
6 organizations representing older adults, and other
7 organizational entities, providers of care, or individuals
8 with demonstrated interest and expertise in the field of home
9 and community care as determined by the Director.

10 Nominations may be presented from any agency or State
11 association with interest in the program. The Director, or his
12 or her designee, shall serve as the permanent co-chair of the
13 advisory committee. One other co-chair shall be nominated and
14 approved by the members of the committee on an annual basis.
15 Committee members' terms of appointment shall be for 4 years
16 with one-quarter of the appointees' terms expiring each year.
17 A member shall continue to serve until his or her replacement
18 is named. The Department shall fill vacancies that have a
19 remaining term of over one year, and this replacement shall
20 occur through the annual replacement of expiring terms. The
21 Director shall designate Department staff to provide technical
22 assistance and staff support to the committee. Department
23 representation shall not constitute membership of the
24 committee. All Committee papers, issues, recommendations,
25 reports, and meeting memoranda are advisory only. The
26 Director, or his or her designee, shall make a written report,

1 as requested by the Committee, regarding issues before the
2 Committee.

3 The Department on Aging and the Department of Human
4 Services shall cooperate in the development and submission of
5 an annual report on programs and services provided under this
6 Section. Such joint report shall be filed with the Governor
7 and the General Assembly on or before March 31 of the following
8 fiscal year ~~September 30 each year.~~

9 The requirement for reporting to the General Assembly
10 shall be satisfied by filing copies of the report as required
11 by Section 3.1 of the General Assembly Organization Act and
12 filing such additional copies with the State Government Report
13 Distribution Center for the General Assembly as is required
14 under paragraph (t) of Section 7 of the State Library Act.

15 Those persons previously found eligible for receiving
16 non-institutional services whose services were discontinued
17 under the Emergency Budget Act of Fiscal Year 1992, and who do
18 not meet the eligibility standards in effect on or after July
19 1, 1992, shall remain ineligible on and after July 1, 1992.
20 Those persons previously not required to cost-share and who
21 were required to cost-share effective March 1, 1992, shall
22 continue to meet cost-share requirements on and after July 1,
23 1992. Beginning July 1, 1992, all clients will be required to
24 meet eligibility, cost-share, and other requirements and will
25 have services discontinued or altered when they fail to meet
26 these requirements.

1 For the purposes of this Section, "flexible senior
2 services" refers to services that require one-time or periodic
3 expenditures including, but not limited to, respite care, home
4 modification, assistive technology, housing assistance, and
5 transportation.

6 The Department shall implement an electronic service
7 verification based on global positioning systems or other
8 cost-effective technology for the Community Care Program no
9 later than January 1, 2014.

10 The Department shall require, as a condition of
11 eligibility, enrollment in the medical assistance program
12 under Article V of the Illinois Public Aid Code (i) beginning
13 August 1, 2013, if the Auditor General has reported that the
14 Department has failed to comply with the reporting
15 requirements of Section 2-27 of the Illinois State Auditing
16 Act; or (ii) beginning June 1, 2014, if the Auditor General has
17 reported that the Department has not undertaken the required
18 actions listed in the report required by subsection (a) of
19 Section 2-27 of the Illinois State Auditing Act.

20 The Department shall delay Community Care Program services
21 until an applicant is determined eligible for medical
22 assistance under Article V of the Illinois Public Aid Code (i)
23 beginning August 1, 2013, if the Auditor General has reported
24 that the Department has failed to comply with the reporting
25 requirements of Section 2-27 of the Illinois State Auditing
26 Act; or (ii) beginning June 1, 2014, if the Auditor General has

1 reported that the Department has not undertaken the required
2 actions listed in the report required by subsection (a) of
3 Section 2-27 of the Illinois State Auditing Act.

4 The Department shall implement co-payments for the
5 Community Care Program at the federally allowable maximum
6 level (i) beginning August 1, 2013, if the Auditor General has
7 reported that the Department has failed to comply with the
8 reporting requirements of Section 2-27 of the Illinois State
9 Auditing Act; or (ii) beginning June 1, 2014, if the Auditor
10 General has reported that the Department has not undertaken
11 the required actions listed in the report required by
12 subsection (a) of Section 2-27 of the Illinois State Auditing
13 Act.

14 The Department shall continue to provide other Community
15 Care Program reports as required by statute.

16 The Department shall conduct a quarterly review of Care
17 Coordination Unit performance and adherence to service
18 guidelines. The quarterly review shall be reported to the
19 Speaker of the House of Representatives, the Minority Leader
20 of the House of Representatives, the President of the Senate,
21 and the Minority Leader of the Senate. The Department shall
22 collect and report longitudinal data on the performance of
23 each care coordination unit. Nothing in this paragraph shall
24 be construed to require the Department to identify specific
25 care coordination units.

26 In regard to community care providers, failure to comply

1 with Department on Aging policies shall be cause for
2 disciplinary action, including, but not limited to,
3 disqualification from serving Community Care Program clients.
4 Each provider, upon submission of any bill or invoice to the
5 Department for payment for services rendered, shall include a
6 notarized statement, under penalty of perjury pursuant to
7 Section 1-109 of the Code of Civil Procedure, that the
8 provider has complied with all Department policies.

9 The Director of the Department on Aging shall make
10 information available to the State Board of Elections as may
11 be required by an agreement the State Board of Elections has
12 entered into with a multi-state voter registration list
13 maintenance system.

14 Within 30 days after July 6, 2017 (the effective date of
15 Public Act 100-23), rates shall be increased to \$18.29 per
16 hour, for the purpose of increasing, by at least \$.72 per hour,
17 the wages paid by those vendors to their employees who provide
18 homemaker services. The Department shall pay an enhanced rate
19 under the Community Care Program to those in-home service
20 provider agencies that offer health insurance coverage as a
21 benefit to their direct service worker employees consistent
22 with the mandates of Public Act 95-713. For State fiscal years
23 2018 and 2019, the enhanced rate shall be \$1.77 per hour. The
24 rate shall be adjusted using actuarial analysis based on the
25 cost of care, but shall not be set below \$1.77 per hour. The
26 Department shall adopt rules, including emergency rules under

1 subsections (y) and (bb) of Section 5-45 of the Illinois
2 Administrative Procedure Act, to implement the provisions of
3 this paragraph.

4 The General Assembly finds it necessary to authorize an
5 aggressive Medicaid enrollment initiative designed to maximize
6 federal Medicaid funding for the Community Care Program which
7 produces significant savings for the State of Illinois. The
8 Department on Aging shall establish and implement a Community
9 Care Program Medicaid Initiative. Under the Initiative, the
10 Department on Aging shall, at a minimum: (i) provide an
11 enhanced rate to adequately compensate care coordination units
12 to enroll eligible Community Care Program clients into
13 Medicaid; (ii) use recommendations from a stakeholder
14 committee on how best to implement the Initiative; and (iii)
15 establish requirements for State agencies to make enrollment
16 in the State's Medical Assistance program easier for seniors.

17 The Community Care Program Medicaid Enrollment Oversight
18 Subcommittee is created as a subcommittee of the Older Adult
19 Services Advisory Committee established in Section 35 of the
20 Older Adult Services Act to make recommendations on how best
21 to increase the number of medical assistance recipients who
22 are enrolled in the Community Care Program. The Subcommittee
23 shall consist of all of the following persons who must be
24 appointed within 30 days after the effective date of this
25 amendatory Act of the 100th General Assembly:

26 (1) The Director of Aging, or his or her designee, who

1 shall serve as the chairperson of the Subcommittee.

2 (2) One representative of the Department of Healthcare
3 and Family Services, appointed by the Director of
4 Healthcare and Family Services.

5 (3) One representative of the Department of Human
6 Services, appointed by the Secretary of Human Services.

7 (4) One individual representing a care coordination
8 unit, appointed by the Director of Aging.

9 (5) One individual from a non-governmental statewide
10 organization that advocates for seniors, appointed by the
11 Director of Aging.

12 (6) One individual representing Area Agencies on
13 Aging, appointed by the Director of Aging.

14 (7) One individual from a statewide association
15 dedicated to Alzheimer's care, support, and research,
16 appointed by the Director of Aging.

17 (8) One individual from an organization that employs
18 persons who provide services under the Community Care
19 Program, appointed by the Director of Aging.

20 (9) One member of a trade or labor union representing
21 persons who provide services under the Community Care
22 Program, appointed by the Director of Aging.

23 (10) One member of the Senate, who shall serve as
24 co-chairperson, appointed by the President of the Senate.

25 (11) One member of the Senate, who shall serve as
26 co-chairperson, appointed by the Minority Leader of the

1 Senate.

2 (12) One member of the House of Representatives, who
3 shall serve as co-chairperson, appointed by the Speaker of
4 the House of Representatives.

5 (13) One member of the House of Representatives, who
6 shall serve as co-chairperson, appointed by the Minority
7 Leader of the House of Representatives.

8 (14) One individual appointed by a labor organization
9 representing frontline employees at the Department of
10 Human Services.

11 The Subcommittee shall provide oversight to the Community
12 Care Program Medicaid Initiative and shall meet quarterly. At
13 each Subcommittee meeting the Department on Aging shall
14 provide the following data sets to the Subcommittee: (A) the
15 number of Illinois residents, categorized by planning and
16 service area, who are receiving services under the Community
17 Care Program and are enrolled in the State's Medical
18 Assistance Program; (B) the number of Illinois residents,
19 categorized by planning and service area, who are receiving
20 services under the Community Care Program, but are not
21 enrolled in the State's Medical Assistance Program; and (C)
22 the number of Illinois residents, categorized by planning and
23 service area, who are receiving services under the Community
24 Care Program and are eligible for benefits under the State's
25 Medical Assistance Program, but are not enrolled in the
26 State's Medical Assistance Program. In addition to this data,

1 the Department on Aging shall provide the Subcommittee with
2 plans on how the Department on Aging will reduce the number of
3 Illinois residents who are not enrolled in the State's Medical
4 Assistance Program but who are eligible for medical assistance
5 benefits. The Department on Aging shall enroll in the State's
6 Medical Assistance Program those Illinois residents who
7 receive services under the Community Care Program and are
8 eligible for medical assistance benefits but are not enrolled
9 in the State's Medicaid Assistance Program. The data provided
10 to the Subcommittee shall be made available to the public via
11 the Department on Aging's website.

12 The Department on Aging, with the involvement of the
13 Subcommittee, shall collaborate with the Department of Human
14 Services and the Department of Healthcare and Family Services
15 on how best to achieve the responsibilities of the Community
16 Care Program Medicaid Initiative.

17 The Department on Aging, the Department of Human Services,
18 and the Department of Healthcare and Family Services shall
19 coordinate and implement a streamlined process for seniors to
20 access benefits under the State's Medical Assistance Program.

21 The Subcommittee shall collaborate with the Department of
22 Human Services on the adoption of a uniform application
23 submission process. The Department of Human Services and any
24 other State agency involved with processing the medical
25 assistance application of any person enrolled in the Community
26 Care Program shall include the appropriate care coordination

1 unit in all communications related to the determination or
2 status of the application.

3 The Community Care Program Medicaid Initiative shall
4 provide targeted funding to care coordination units to help
5 seniors complete their applications for medical assistance
6 benefits. On and after July 1, 2019, care coordination units
7 shall receive no less than \$200 per completed application,
8 which rate may be included in a bundled rate for initial intake
9 services when Medicaid application assistance is provided in
10 conjunction with the initial intake process for new program
11 participants.

12 The Community Care Program Medicaid Initiative shall cease
13 operation 5 years after the effective date of this amendatory
14 Act of the 100th General Assembly, after which the
15 Subcommittee shall dissolve.

16 (Source: P.A. 101-10, eff. 6-5-19; 102-1071, eff. 6-10-22.)

17 (20 ILCS 105/4.07)

18 Sec. 4.07. Home-delivered meals.

19 (a) Every citizen of the State of Illinois who qualifies
20 for home-delivered meals under the federal Older Americans Act
21 shall be provided services, subject to appropriation. The
22 Department shall file a report with the General Assembly and
23 the Illinois Council on Aging by March 31 of the following
24 fiscal year ~~January 1 of each year~~. The report shall include,
25 but not be limited to, the following information: (i)

1 estimates, by county, of citizens denied service due to
2 insufficient funds during the preceding fiscal year and the
3 potential impact on service delivery of any additional funds
4 appropriated for the current fiscal year; (ii) geographic
5 areas and special populations unserved and underserved in the
6 preceding fiscal year; (iii) estimates of additional funds
7 needed to permit the full funding of the program and the
8 statewide provision of services in the next fiscal year,
9 including staffing and equipment needed to prepare and deliver
10 meals; (iv) recommendations for increasing the amount of
11 federal funding captured for the program; (v) recommendations
12 for serving unserved and underserved areas and special
13 populations, to include rural areas, dietetic meals, weekend
14 meals, and 2 or more meals per day; and (vi) any other
15 information needed to assist the General Assembly and the
16 Illinois Council on Aging in developing a plan to address
17 unserved and underserved areas of the State.

18 (b) Subject to appropriation, on an annual basis each
19 recipient of home-delivered meals shall receive a fact sheet
20 developed by the Department on Aging with a current list of
21 toll-free numbers to access information on various health
22 conditions, elder abuse, and programs for persons 60 years of
23 age and older. The fact sheet shall be written in a language
24 that the client understands, if possible. In addition, each
25 recipient of home-delivered meals shall receive updates on any
26 new program for which persons 60 years of age and older may be

1 eligible.

2 (Source: P.A. 102-253, eff. 8-6-21.)

3 Section 90-10. The Respite Program Act is amended by
4 changing Section 12 as follows:

5 (320 ILCS 10/12) (from Ch. 23, par. 6212)

6 Sec. 12. Annual report. The Director shall submit a report
7 by March 31 of the following fiscal year ~~each year~~ to the
8 Governor and the General Assembly detailing the progress of
9 the respite care services provided under this Act and shall
10 also include an estimate of the demand for respite care
11 services over the next 10 years.

12 (Source: P.A. 100-972, eff. 1-1-19.)

13 ARTICLE 95.

14 Section 95-5. The Hospital Licensing Act is amended by
15 changing Section 6.09 as follows:

16 (210 ILCS 85/6.09) (from Ch. 111 1/2, par. 147.09)

17 Sec. 6.09. (a) In order to facilitate the orderly
18 transition of aged patients and patients with disabilities
19 from hospitals to post-hospital care, whenever a patient who
20 qualifies for the federal Medicare program is hospitalized,
21 the patient shall be notified of discharge at least 24 hours

1 prior to discharge from the hospital. With regard to pending
2 discharges to a skilled nursing facility, the hospital must
3 notify the case coordination unit, as defined in 89 Ill. Adm.
4 Code 240.260, at least 24 hours prior to discharge. When the
5 assessment is completed in the hospital, the case coordination
6 unit shall provide a copy of the required assessment
7 documentation directly to the nursing home to which the
8 patient is being discharged prior to discharge. The Department
9 on Aging shall provide notice of this requirement to case
10 coordination units. When a case coordination unit is unable to
11 complete an assessment in a hospital prior to the discharge of
12 a patient, 60 years of age or older, to a nursing home, the
13 case coordination unit shall notify the Department on Aging
14 which shall notify the Department of Healthcare and Family
15 Services. ~~The Department of Healthcare and Family Services and~~
16 ~~the~~ Department on Aging shall adopt rules to address these
17 instances to ensure that the patient is able to access nursing
18 home care, the nursing home is not penalized for accepting the
19 admission, and the patient's timely discharge from the
20 hospital is not delayed, to the extent permitted under federal
21 law or regulation. Nothing in this subsection shall preclude
22 federal requirements for a pre-admission screening/mental
23 health (PAS/MH) as required under Section 2-201.5 of the
24 Nursing Home Care Act or State or federal law or regulation. If
25 home health services are ordered, the hospital must inform its
26 designated case coordination unit, as defined in 89 Ill. Adm.

1 Code 240.260, of the pending discharge and must provide the
2 patient with the case coordination unit's telephone number and
3 other contact information.

4 (b) Every hospital shall develop procedures for a
5 physician with medical staff privileges at the hospital or any
6 appropriate medical staff member to provide the discharge
7 notice prescribed in subsection (a) of this Section. The
8 procedures must include prohibitions against discharging or
9 referring a patient to any of the following if unlicensed,
10 uncertified, or unregistered: (i) a board and care facility,
11 as defined in the Board and Care Home Act; (ii) an assisted
12 living and shared housing establishment, as defined in the
13 Assisted Living and Shared Housing Act; (iii) a facility
14 licensed under the Nursing Home Care Act, the Specialized
15 Mental Health Rehabilitation Act of 2013, the ID/DD Community
16 Care Act, or the MC/DD Act; (iv) a supportive living facility,
17 as defined in Section 5-5.01a of the Illinois Public Aid Code;
18 or (v) a free-standing hospice facility licensed under the
19 Hospice Program Licensing Act if licensure, certification, or
20 registration is required. The Department of Public Health
21 shall annually provide hospitals with a list of licensed,
22 certified, or registered board and care facilities, assisted
23 living and shared housing establishments, nursing homes,
24 supportive living facilities, facilities licensed under the
25 ID/DD Community Care Act, the MC/DD Act, or the Specialized
26 Mental Health Rehabilitation Act of 2013, and hospice

1 facilities. Reliance upon this list by a hospital shall
2 satisfy compliance with this requirement. The procedure may
3 also include a waiver for any case in which a discharge notice
4 is not feasible due to a short length of stay in the hospital
5 by the patient, or for any case in which the patient
6 voluntarily desires to leave the hospital before the
7 expiration of the 24 hour period.

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

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

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

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

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

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

3 (5) are independently ambulatory or mobile for more
4 than a temporary period of time.

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

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

21 (Source: P.A. 102-538, eff. 8-20-21.)

22 Section 95-10. The Illinois Insurance Code is amended by
23 changing Section 5.5 as follows:

24 (215 ILCS 5/5.5)

1 Sec. 5.5. Compliance with the Department of Healthcare and
2 Family Services. A company authorized to do business in this
3 State or accredited by the State to issue policies of health
4 insurance, including but not limited to, self-insured plans,
5 group health plans (as defined in Section 607(1) of the
6 Employee Retirement Income Security Act of 1974), service
7 benefit plans, managed care organizations, pharmacy benefit
8 managers, or other parties that are by statute, contract, or
9 agreement legally responsible for payment of a claim for a
10 health care item or service as a condition of doing business in
11 the State must:

12 (1) provide to the Department of Healthcare and Family
13 Services, or any successor agency, on at least a quarterly
14 basis if so requested by the Department, information to
15 determine during what period any individual may be, or may
16 have been, covered by a health insurer and the nature of
17 the coverage that is or was provided by the health
18 insurer, including the name, address, and identifying
19 number of the plan;

20 (2) accept the State's right of recovery and the
21 assignment to the State of any right of an individual or
22 other entity to payment from the party for an item or
23 service for which payment has been made under the medical
24 programs of the Department of Healthcare and Family
25 Services, or any successor or authorized agency, under
26 this Code, ~~or~~ the Illinois Public Aid Code, or any other

1 applicable law; and (other than parties expressly excluded
2 under 42 U.S.C. 1396a(a)(25)(I)(ii)(II)) accept
3 authorization provided by the State that the item or
4 service is covered under such medical programs for the
5 individual, as if the State's authorization was the prior
6 authorization made by the company for the item or service;

7 (3) not later than 60 days after receiving ~~respond to~~
8 any inquiry by the Department of Healthcare and Family
9 Services regarding a claim for payment for any health care
10 item or service that is submitted not later than 3 years
11 after the date of the provision of such health care item or
12 service, respond to such inquiry; and

13 (4) agree not to deny a claim submitted by the
14 Department of Healthcare and Family Services solely on the
15 basis of the date of submission of the claim, the type or
16 format of the claim form, ~~or~~ a failure to present proper
17 documentation at the point-of-sale that is the basis of
18 the claim, or (other than parties expressly excluded under
19 42 U.S.C. 1396a(a)(25)(I)(iv)) a failure to obtain a prior
20 authorization for the item or service for which the claim
21 is being submitted if (i) the claim is submitted by the
22 Department of Healthcare and Family Services within the
23 3-year period beginning on the date on which the item or
24 service was furnished and (ii) any action by the
25 Department of Healthcare and Family Services to enforce
26 its rights with respect to such claim is commenced within

1 6 years of its submission of such claim.

2 The Department of Healthcare and Family Services may
3 impose an administrative penalty as provided under Section
4 12-4.45 of the Illinois Public Aid Code on entities that have
5 established a pattern of failure to provide the information
6 required under this Section, or in cases in which the
7 Department of Healthcare and Family Services has determined
8 that an entity that provides health insurance coverage has
9 established a pattern of failure to provide the information
10 required under this Section, and has subsequently certified
11 that determination, along with supporting documentation, to
12 the Director of the Department of Insurance, the Director of
13 the Department of Insurance, based upon the certification of
14 determination made by the Department of Healthcare and Family
15 Services, may commence regulatory proceedings in accordance
16 with all applicable provisions of the Illinois Insurance Code.
17 (Source: P.A. 98-130, eff. 8-2-13.)

18 Section 95-15. The Illinois Public Aid Code is amended by
19 changing Sections 5-5 and 12-8 as follows:

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

21 Sec. 5-5. Medical services. The Illinois Department, by
22 rule, shall determine the quantity and quality of and the rate
23 of reimbursement for the medical assistance for which payment
24 will be authorized, and the medical services to be provided,

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

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

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

1 Article.

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

7 Notwithstanding any other provision of this Section, all
8 tobacco cessation medications approved by the United States
9 Food and Drug Administration and all individual and group
10 tobacco cessation counseling services and telephone-based
11 counseling services and tobacco cessation medications provided
12 through the Illinois Tobacco Quitline shall be covered under
13 the medical assistance program for persons who are otherwise
14 eligible for assistance under this Article. The Department
15 shall comply with all federal requirements necessary to obtain
16 federal financial participation, as specified in 42 CFR
17 433.15(b)(7), for telephone-based counseling services provided
18 through the Illinois Tobacco Quitline, including, but not
19 limited to: (i) entering into a memorandum of understanding or
20 interagency agreement with the Department of Public Health, as
21 administrator of the Illinois Tobacco Quitline; and (ii)
22 developing a cost allocation plan for Medicaid-allowable
23 Illinois Tobacco Quitline services in accordance with 45 CFR
24 95.507. The Department shall submit the memorandum of
25 understanding or interagency agreement, the cost allocation
26 plan, and all other necessary documentation to the Centers for

1 Medicare and Medicaid Services for review and approval.
2 Coverage under this paragraph shall be contingent upon federal
3 approval.

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

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

1 payment and shall be reimbursed at the Department's or the
2 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

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

25 On and after July 1, 2018, targeted dental services, as
26 set forth in Exhibit D of the Consent Decree entered by the

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

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

22 On and after January 1, 2022, the Department of Healthcare
23 and Family Services shall administer and regulate a
24 school-based dental program that allows for the out-of-office
25 delivery of preventative dental services in a school setting
26 to children under 19 years of age. The Department shall

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

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

22 The Department of Healthcare and Family Services must
23 provide coverage and reimbursement for amino acid-based
24 elemental formulas, regardless of delivery method, for the
25 diagnosis and treatment of (i) eosinophilic disorders and (ii)
26 short bowel syndrome when the prescribing physician has issued

1 a written order stating that the amino acid-based elemental
2 formula is medically necessary.

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

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

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

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

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

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

26 (F) A diagnostic mammogram when medically necessary,

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

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

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

16 For purposes of this Section:

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

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

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

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

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

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

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

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

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

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

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

22 The Department shall convene an expert panel, including
23 representatives of hospitals, free-standing breast cancer
24 treatment centers, breast cancer quality organizations, and
25 doctors, including breast surgeons, reconstructive breast
26 surgeons, oncologists, and primary care providers to establish

1 quality standards for breast cancer treatment.

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

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

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

24 The Department shall devise a means of case-managing or
25 patient navigation for beneficiaries diagnosed with breast
26 cancer. This program shall initially operate as a pilot

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

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

20 The Department shall provide coverage and reimbursement
21 for a human papillomavirus (HPV) vaccine that is approved for
22 marketing by the federal Food and Drug Administration for all
23 persons between the ages of 9 and 45. Subject to federal
24 approval, the Department shall provide coverage and
25 reimbursement for a human papillomavirus (HPV) vaccine for ~~and~~
26 persons of the age of 46 and above who have been diagnosed with

1 cervical dysplasia with a high risk of recurrence or
2 progression. The Department shall disallow any
3 preauthorization requirements for the administration of the
4 human papillomavirus (HPV) vaccine.

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

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

24 All medical providers providing medical assistance to
25 pregnant individuals under this Code shall receive information
26 from the Department on the availability of services under any

1 program providing case management services for addicted
2 individuals, including information on appropriate referrals
3 for other social services that may be needed by addicted
4 individuals in addition to treatment for addiction.

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

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

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

26 The Illinois Department may develop and contract with

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

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

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

25 (2) The Department may elect to consider and negotiate
26 financial incentives to encourage the development of

1 Partnerships and the efficient delivery of medical care.

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

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

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

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

1 The Illinois Department shall require health care
2 providers to maintain records that document the medical care
3 and services provided to recipients of Medical Assistance
4 under this Article. Such records must be retained for a period
5 of not less than 6 years from the date of service or as
6 provided by applicable State law, whichever period is longer,
7 except that if an audit is initiated within the required
8 retention period then the records must be retained until the
9 audit is completed and every exception is resolved. The
10 Illinois Department shall require health care providers to
11 make available, when authorized by the patient, in writing,
12 the medical records in a timely fashion to other health care
13 providers who are treating or serving persons eligible for
14 Medical Assistance under this Article. All dispensers of
15 medical services shall be required to maintain and retain
16 business and professional records sufficient to fully and
17 accurately document the nature, scope, details and receipt of
18 the health care provided to persons eligible for medical
19 assistance under this Code, in accordance with regulations
20 promulgated by the Illinois Department. The rules and
21 regulations shall require that proof of the receipt of
22 prescription drugs, dentures, prosthetic devices and
23 eyeglasses by eligible persons under this Section accompany
24 each claim for reimbursement submitted by the dispenser of
25 such medical services. No such claims for reimbursement shall
26 be approved for payment by the Illinois Department without

1 such proof of receipt, unless the Illinois Department shall
2 have put into effect and shall be operating a system of
3 post-payment audit and review which shall, on a sampling
4 basis, be deemed adequate by the Illinois Department to assure
5 that such drugs, dentures, prosthetic devices and eyeglasses
6 for which payment is being made are actually being received by
7 eligible recipients. Within 90 days after September 16, 1984
8 (the effective date of Public Act 83-1439), the Illinois
9 Department shall establish a current list of acquisition costs
10 for all prosthetic devices and any other items recognized as
11 medical equipment and supplies reimbursable under this Article
12 and shall update such list on a quarterly basis, except that
13 the acquisition costs of all prescription drugs shall be
14 updated no less frequently than every 30 days as required by
15 Section 5-5.12.

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

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

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

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

1 inquiries could indicate potential existence of claims or
2 liens for the Illinois Department.

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

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

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

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

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

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

23 (2) In the case of errors attributable to the Illinois
24 Department or any of its claims processing intermediaries
25 which result in an inability to receive, process, or
26 adjudicate a claim, the 180-day period shall not begin

1 until the provider has been notified of the error.

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

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

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

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

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

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

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

22 The Illinois Department shall enter into agreements with
23 State agencies and departments, and is authorized to enter
24 into agreements with federal agencies and departments, under
25 which such agencies and departments shall share data necessary
26 for medical assistance program integrity functions and

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

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

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

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

1 recipients. No later than 15 months after the effective date
2 of the rule adopted pursuant to this paragraph, all providers
3 must meet the accreditation requirement.

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

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

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

1 permit long term care providers access to eligibility scores
2 for individuals with an admission date who are seeking or
3 receiving services from the long term care provider. In order
4 to select the minimum level of care eligibility criteria, the
5 Governor shall establish a workgroup that includes affected
6 agency representatives and stakeholders representing the
7 institutional and home and community-based long term care
8 interests. This Section shall not restrict the Department from
9 implementing lower level of care eligibility criteria for
10 community-based services in circumstances where federal
11 approval has been granted.

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

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

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

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

26 (c) current rate structures and proposed changes in

1 those rate structures for the various medical vendors; and

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

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

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

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

25 Because kidney transplantation can be an appropriate,
26 cost-effective alternative to renal dialysis when medically

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

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

26 On or after July 1, 2015, opioid antagonists prescribed

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

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

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

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

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

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

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

17 (Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20;
18 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article
19 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section
20 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22;
21 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff.
22 1-1-22; 102-665, eff. 10-8-21; 102-813, eff. 5-13-22;
23 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22; 102-1038 eff.
24 1-1-23; revised 2-5-23.)

1 Sec. 12-8. Public Assistance Emergency Revolving Fund -
2 Uses. The Public Assistance Emergency Revolving Fund,
3 established by Act approved July 8, 1955 shall be held by the
4 Illinois Department and shall be used for the following
5 purposes:

6 1. To provide immediate financial aid to applicants in
7 acute need who have been determined eligible for aid under
8 Articles III, IV, or V.

9 2. To provide emergency aid to recipients under said
10 Articles who have failed to receive their grants because
11 of mail box or other thefts, or who are victims of a
12 burnout, eviction, or other circumstances causing
13 privation, in which cases the delays incident to the
14 issuance of grants from appropriations would cause
15 hardship and suffering.

16 3. To provide emergency aid for transportation, meals
17 and lodging to applicants who are referred to cities other
18 than where they reside for physical examinations to
19 establish blindness or disability, or to determine the
20 incapacity of the parent of a dependent child.

21 4. To provide emergency transportation expense
22 allowances to recipients engaged in vocational training
23 and rehabilitation projects.

24 5. To assist public aid applicants in obtaining copies
25 of birth certificates, death certificates, marriage
26 licenses or other similar legal documents which may

1 facilitate the verification of eligibility for public aid
2 under this Code.

3 6. To provide immediate payments to current or former
4 recipients of child support enforcement services, or
5 refunds to responsible relatives, for child support made
6 to the Illinois Department under Title IV-D of the Social
7 Security Act when such recipients of services or
8 responsible relatives are legally entitled to all or part
9 of such child support payments under applicable State or
10 federal law.

11 7. To provide payments to individuals or providers of
12 transportation to and from medical care for the benefit of
13 recipients under Articles III, IV, V, and VI.

14 8. To provide immediate payment of fees, as follows:

15 (A) To sheriffs and other public officials
16 authorized by law to serve process in judicial and
17 administrative child support actions in the State of
18 Illinois and other states.

19 (B) To county clerks, recorders of deeds, and
20 other public officials and keepers of real property
21 records in order to perfect and release real property
22 liens.

23 (C) To State and local officials in connection
24 with the processing of Qualified Illinois Domestic
25 Relations Orders.

26 (D) To the State Registrar of Vital Records, local

1 registrars of vital records, or other public officials
2 and keepers of voluntary acknowledgment of paternity
3 forms.

4 Disbursements from the Public Assistance Emergency
5 Revolving Fund shall be made by the Illinois Department.

6 Expenditures from the Public Assistance Emergency
7 Revolving Fund shall be for purposes which are properly
8 chargeable to appropriations made to the Illinois Department,
9 or, in the case of payments under subparagraphs 6 and 8, to the
10 Child Support Enforcement Trust Fund or the Child Support
11 Administrative Fund, except that no expenditure, other than
12 payment of the fees provided for under subparagraph 8 of this
13 Section, shall be made for purposes which are properly
14 chargeable to appropriations for the following objects:
15 personal services; extra help; state contributions to
16 retirement system; state contributions to Social Security;
17 state contributions for employee group insurance; contractual
18 services; travel; commodities; printing; equipment; electronic
19 data processing; operation of auto equipment;
20 telecommunications services; library books; and refunds. The
21 Illinois Department shall reimburse the Public Assistance
22 Emergency Revolving Fund by warrants drawn by the State
23 Comptroller on the appropriation or appropriations which are
24 so chargeable, or, in the case of payments under subparagraphs
25 6 and 8, by warrants drawn on the Child Support Enforcement
26 Trust Fund or the Child Support Administrative Fund, payable

1 to the Revolving Fund.
2 (Source: P.A. 97-735, eff. 7-3-12.)

3 ARTICLE 100.

4 Section 100-5. The Illinois Public Aid Code is amended by
5 changing Section 5-5.01a as follows:

6 (305 ILCS 5/5-5.01a)

7 Sec. 5-5.01a. Supportive living facilities program.

8 (a) The Department shall establish and provide oversight
9 for a program of supportive living facilities that seek to
10 promote resident independence, dignity, respect, and
11 well-being in the most cost-effective manner.

12 A supportive living facility is (i) a free-standing
13 facility or (ii) a distinct physical and operational entity
14 within a mixed-use building that meets the criteria
15 established in subsection (d). A supportive living facility
16 integrates housing with health, personal care, and supportive
17 services and is a designated setting that offers residents
18 their own separate, private, and distinct living units.

19 Sites for the operation of the program shall be selected
20 by the Department based upon criteria that may include the
21 need for services in a geographic area, the availability of
22 funding, and the site's ability to meet the standards.

23 (b) Beginning July 1, 2014, subject to federal approval,

1 the Medicaid rates for supportive living facilities shall be
2 equal to the supportive living facility Medicaid rate
3 effective on June 30, 2014 increased by 8.85%. Once the
4 assessment imposed at Article V-G of this Code is determined
5 to be a permissible tax under Title XIX of the Social Security
6 Act, the Department shall increase the Medicaid rates for
7 supportive living facilities effective on July 1, 2014 by
8 9.09%. The Department shall apply this increase retroactively
9 to coincide with the imposition of the assessment in Article
10 V-G of this Code in accordance with the approval for federal
11 financial participation by the Centers for Medicare and
12 Medicaid Services.

13 The Medicaid rates for supportive living facilities
14 effective on July 1, 2017 must be equal to the rates in effect
15 for supportive living facilities on June 30, 2017 increased by
16 2.8%.

17 The Medicaid rates for supportive living facilities
18 effective on July 1, 2018 must be equal to the rates in effect
19 for supportive living facilities on June 30, 2018.

20 Subject to federal approval, the Medicaid rates for
21 supportive living services on and after July 1, 2019 must be at
22 least 54.3% of the average total nursing facility services per
23 diem for the geographic areas defined by the Department while
24 maintaining the rate differential for dementia care and must
25 be updated whenever the total nursing facility service per
26 diems are updated. Beginning July 1, 2022, upon the

1 implementation of the Patient Driven Payment Model, Medicaid
2 rates for supportive living services must be at least 54.3% of
3 the average total nursing services per diem rate for the
4 geographic areas. For purposes of this provision, the average
5 total nursing services per diem rate shall include all add-ons
6 for nursing facilities for the geographic area provided for in
7 Section 5-5.2. The rate differential for dementia care must be
8 maintained in these rates and the rates shall be updated
9 whenever nursing facility per diem rates are updated.

10 (c) The Department may adopt rules to implement this
11 Section. Rules that establish or modify the services,
12 standards, and conditions for participation in the program
13 shall be adopted by the Department in consultation with the
14 Department on Aging, the Department of Rehabilitation
15 Services, and the Department of Mental Health and
16 Developmental Disabilities (or their successor agencies).

17 (d) Subject to federal approval by the Centers for
18 Medicare and Medicaid Services, the Department shall accept
19 for consideration of certification under the program any
20 application for a site or building where distinct parts of the
21 site or building are designated for purposes other than the
22 provision of supportive living services, but only if:

- 23 (1) those distinct parts of the site or building are
24 not designated for the purpose of providing assisted
25 living services as required under the Assisted Living and
26 Shared Housing Act;

1 (2) those distinct parts of the site or building are
2 completely separate from the part of the building used for
3 the provision of supportive living program services,
4 including separate entrances;

5 (3) those distinct parts of the site or building do
6 not share any common spaces with the part of the building
7 used for the provision of supportive living program
8 services; and

9 (4) those distinct parts of the site or building do
10 not share staffing with the part of the building used for
11 the provision of supportive living program services.

12 (e) Facilities or distinct parts of facilities which are
13 selected as supportive living facilities and are in good
14 standing with the Department's rules are exempt from the
15 provisions of the Nursing Home Care Act and the Illinois
16 Health Facilities Planning Act.

17 (f) Section 9817 of the American Rescue Plan Act of 2021
18 (Public Law 117-2) authorizes a 10% enhanced federal medical
19 assistance percentage for supportive living services for a
20 12-month period from April 1, 2021 through March 31, 2022.
21 Subject to federal approval, including the approval of any
22 necessary waiver amendments or other federally required
23 documents or assurances, for a 12-month period the Department
24 must pay a supplemental \$26 per diem rate to all supportive
25 living facilities with the additional federal financial
26 participation funds that result from the enhanced federal

1 medical assistance percentage from April 1, 2021 through March
2 31, 2022. The Department may issue parameters around how the
3 supplemental payment should be spent, including quality
4 improvement activities. The Department may alter the form,
5 methods, or timeframes concerning the supplemental per diem
6 rate to comply with any subsequent changes to federal law,
7 changes made by guidance issued by the federal Centers for
8 Medicare and Medicaid Services, or other changes necessary to
9 receive the enhanced federal medical assistance percentage.

10 (g) All applications for the expansion of supportive
11 living dementia care settings involving sites not approved by
12 the Department on the effective date of this amendatory Act of
13 the 103rd General Assembly may allow new elderly non-dementia
14 units in addition to new dementia care units. The Department
15 may approve such applications only if the application has: (1)
16 no more than one non-dementia care unit for each dementia care
17 unit and (2) the site is not located within 4 miles of an
18 existing supportive living program site in Cook County
19 (including the City of Chicago), not located within 12 miles
20 of an existing supportive living program site in DuPage
21 County, Kane County, Lake County, McHenry County, or Will
22 County, or not located within 25 miles of an existing
23 supportive living program site in any other county.

24 (Source: P.A. 101-10, eff. 6-5-19; 102-43, eff. 7-6-21;
25 102-699, eff. 4-19-22.)

1 ARTICLE 105.

2 Section 105-5. The Illinois Public Aid Code is amended by
3 changing Section 5A-2 as follows:

4 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

5 (Section scheduled to be repealed on December 31, 2026)

6 Sec. 5A-2. Assessment.

7 (a) (1) Subject to Sections 5A-3 and 5A-10, for State
8 fiscal years 2009 through 2018, or as long as continued under
9 Section 5A-16, an annual assessment on inpatient services is
10 imposed on each hospital provider in an amount equal to
11 \$218.38 multiplied by the difference of the hospital's
12 occupied bed days less the hospital's Medicare bed days,
13 provided, however, that the amount of \$218.38 shall be
14 increased by a uniform percentage to generate an amount equal
15 to 75% of the State share of the payments authorized under
16 Section 5A-12.5, with such increase only taking effect upon
17 the date that a State share for such payments is required under
18 federal law. For the period of April through June 2015, the
19 amount of \$218.38 used to calculate the assessment under this
20 paragraph shall, by emergency rule under subsection (s) of
21 Section 5-45 of the Illinois Administrative Procedure Act, be
22 increased by a uniform percentage to generate \$20,250,000 in
23 the aggregate for that period from all hospitals subject to
24 the annual assessment under this paragraph.

1 (2) In addition to any other assessments imposed under
2 this Article, effective July 1, 2016 and semi-annually
3 thereafter through June 2018, or as provided in Section 5A-16,
4 in addition to any federally required State share as
5 authorized under paragraph (1), the amount of \$218.38 shall be
6 increased by a uniform percentage to generate an amount equal
7 to 75% of the ACA Assessment Adjustment, as defined in
8 subsection (b-6) of this Section.

9 For State fiscal years 2009 through 2018, or as provided
10 in Section 5A-16, a hospital's occupied bed days and Medicare
11 bed days shall be determined using the most recent data
12 available from each hospital's 2005 Medicare cost report as
13 contained in the Healthcare Cost Report Information System
14 file, for the quarter ending on December 31, 2006, without
15 regard to any subsequent adjustments or changes to such data.
16 If a hospital's 2005 Medicare cost report is not contained in
17 the Healthcare Cost Report Information System, then the
18 Illinois Department may obtain the hospital provider's
19 occupied bed days and Medicare bed days from any source
20 available, including, but not limited to, records maintained
21 by the hospital provider, which may be inspected at all times
22 during business hours of the day by the Illinois Department or
23 its duly authorized agents and employees.

24 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
25 fiscal years 2019 and 2020, an annual assessment on inpatient
26 services is imposed on each hospital provider in an amount

1 equal to \$197.19 multiplied by the difference of the
2 hospital's occupied bed days less the hospital's Medicare bed
3 days. For State fiscal years 2019 and 2020, a hospital's
4 occupied bed days and Medicare bed days shall be determined
5 using the most recent data available from each hospital's 2015
6 Medicare cost report as contained in the Healthcare Cost
7 Report Information System file, for the quarter ending on
8 March 31, 2017, without regard to any subsequent adjustments
9 or changes to such data. If a hospital's 2015 Medicare cost
10 report is not contained in the Healthcare Cost Report
11 Information System, then the Illinois Department may obtain
12 the hospital provider's occupied bed days and Medicare bed
13 days from any source available, including, but not limited to,
14 records maintained by the hospital provider, which may be
15 inspected at all times during business hours of the day by the
16 Illinois Department or its duly authorized agents and
17 employees. Notwithstanding any other provision in this
18 Article, for a hospital provider that did not have a 2015
19 Medicare cost report, but paid an assessment in State fiscal
20 year 2018 on the basis of hypothetical data, that assessment
21 amount shall be used for State fiscal years 2019 and 2020.

22 (4) Subject to Sections 5A-3 and 5A-10 and to subsection
23 (b-8), for the period of July 1, 2020 through December 31, 2020
24 and calendar years 2021 through 2026, an annual assessment on
25 inpatient services is imposed on each hospital provider in an
26 amount equal to \$221.50 multiplied by the difference of the

1 hospital's occupied bed days less the hospital's Medicare bed
2 days, provided however: for the period of July 1, 2020 through
3 December 31, 2020, (i) the assessment shall be equal to 50% of
4 the annual amount; and (ii) the amount of \$221.50 shall be
5 retroactively adjusted by a uniform percentage to generate an
6 amount equal to 50% of the Assessment Adjustment, as defined
7 in subsection (b-7). For the period of July 1, 2020 through
8 December 31, 2020 and calendar years 2021 through 2026, a
9 hospital's occupied bed days and Medicare bed days shall be
10 determined using the most recent data available from each
11 hospital's 2015 Medicare cost report as contained in the
12 Healthcare Cost Report Information System file, for the
13 quarter ending on March 31, 2017, without regard to any
14 subsequent adjustments or changes to such data. If a
15 hospital's 2015 Medicare cost report is not contained in the
16 Healthcare Cost Report Information System, then the Illinois
17 Department may obtain the hospital provider's occupied bed
18 days and Medicare bed days from any source available,
19 including, but not limited to, records maintained by the
20 hospital provider, which may be inspected at all times during
21 business hours of the day by the Illinois Department or its
22 duly authorized agents and employees. Should the change in the
23 assessment methodology for fiscal years 2021 through December
24 31, 2022 not be approved on or before June 30, 2020, the
25 assessment and payments under this Article in effect for
26 fiscal year 2020 shall remain in place until the new

1 assessment is approved. If the assessment methodology for July
2 1, 2020 through December 31, 2022, is approved on or after July
3 1, 2020, it shall be retroactive to July 1, 2020, subject to
4 federal approval and provided that the payments authorized
5 under Section 5A-12.7 have the same effective date as the new
6 assessment methodology. In giving retroactive effect to the
7 assessment approved after June 30, 2020, credit toward the new
8 assessment shall be given for any payments of the previous
9 assessment for periods after June 30, 2020. Notwithstanding
10 any other provision of this Article, for a hospital provider
11 that did not have a 2015 Medicare cost report, but paid an
12 assessment in State Fiscal Year 2020 on the basis of
13 hypothetical data, the data that was the basis for the 2020
14 assessment shall be used to calculate the assessment under
15 this paragraph until December 31, 2023. Beginning July 1, 2022
16 and through December 31, 2024, a safety-net hospital that had
17 a change of ownership in calendar year 2021, and whose
18 inpatient utilization had decreased by 90% from the prior year
19 and prior to the change of ownership, may be eligible to pay a
20 tax based on hypothetical data based on a determination of
21 financial distress by the Department. Subject to federal
22 approval, the Department may, by January 1, 2024, develop a
23 hypothetical tax for a specialty cancer hospital which had a
24 structural change of ownership during calendar year 2022 from
25 a for-profit entity to a non-profit entity, and which has
26 experienced a decline of 60% or greater in inpatient days of

1 care as compared to the prior owners 2015 Medicare cost
2 report. This change of ownership may make the hospital
3 eligible for a hypothetical tax under the new hospital
4 provision of the assessment defined in this Section. This new
5 hypothetical tax may be applicable from January 1, 2024
6 through December 31, 2026.

7 (b) (Blank).

8 (b-5) (1) Subject to Sections 5A-3 and 5A-10, for the
9 portion of State fiscal year 2012, beginning June 10, 2012
10 through June 30, 2012, and for State fiscal years 2013 through
11 2018, or as provided in Section 5A-16, an annual assessment on
12 outpatient services is imposed on each hospital provider in an
13 amount equal to .008766 multiplied by the hospital's
14 outpatient gross revenue, provided, however, that the amount
15 of .008766 shall be increased by a uniform percentage to
16 generate an amount equal to 25% of the State share of the
17 payments authorized under Section 5A-12.5, with such increase
18 only taking effect upon the date that a State share for such
19 payments is required under federal law. For the period
20 beginning June 10, 2012 through June 30, 2012, the annual
21 assessment on outpatient services shall be prorated by
22 multiplying the assessment amount by a fraction, the numerator
23 of which is 21 days and the denominator of which is 365 days.
24 For the period of April through June 2015, the amount of
25 .008766 used to calculate the assessment under this paragraph
26 shall, by emergency rule under subsection (s) of Section 5-45

1 of the Illinois Administrative Procedure Act, be increased by
2 a uniform percentage to generate \$6,750,000 in the aggregate
3 for that period from all hospitals subject to the annual
4 assessment under this paragraph.

5 (2) In addition to any other assessments imposed under
6 this Article, effective July 1, 2016 and semi-annually
7 thereafter through June 2018, in addition to any federally
8 required State share as authorized under paragraph (1), the
9 amount of .008766 shall be increased by a uniform percentage
10 to generate an amount equal to 25% of the ACA Assessment
11 Adjustment, as defined in subsection (b-6) of this Section.

12 For the portion of State fiscal year 2012, beginning June
13 10, 2012 through June 30, 2012, and State fiscal years 2013
14 through 2018, or as provided in Section 5A-16, a hospital's
15 outpatient gross revenue shall be determined using the most
16 recent data available from each hospital's 2009 Medicare cost
17 report as contained in the Healthcare Cost Report Information
18 System file, for the quarter ending on June 30, 2011, without
19 regard to any subsequent adjustments or changes to such data.
20 If a hospital's 2009 Medicare cost report is not contained in
21 the Healthcare Cost Report Information System, then the
22 Department may obtain the hospital provider's outpatient gross
23 revenue from any source available, including, but not limited
24 to, records maintained by the hospital provider, which may be
25 inspected at all times during business hours of the day by the
26 Department or its duly authorized agents and employees.

1 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
2 fiscal years 2019 and 2020, an annual assessment on outpatient
3 services is imposed on each hospital provider in an amount
4 equal to .01358 multiplied by the hospital's outpatient gross
5 revenue. For State fiscal years 2019 and 2020, a hospital's
6 outpatient gross revenue shall be determined using the most
7 recent data available from each hospital's 2015 Medicare cost
8 report as contained in the Healthcare Cost Report Information
9 System file, for the quarter ending on March 31, 2017, without
10 regard to any subsequent adjustments or changes to such data.
11 If a hospital's 2015 Medicare cost report is not contained in
12 the Healthcare Cost Report Information System, then the
13 Department may obtain the hospital provider's outpatient gross
14 revenue from any source available, including, but not limited
15 to, records maintained by the hospital provider, which may be
16 inspected at all times during business hours of the day by the
17 Department or its duly authorized agents and employees.
18 Notwithstanding any other provision in this Article, for a
19 hospital provider that did not have a 2015 Medicare cost
20 report, but paid an assessment in State fiscal year 2018 on the
21 basis of hypothetical data, that assessment amount shall be
22 used for State fiscal years 2019 and 2020.

23 (4) Subject to Sections 5A-3 and 5A-10 and to subsection
24 (b-8), for the period of July 1, 2020 through December 31, 2020
25 and calendar years 2021 through 2026, an annual assessment on
26 outpatient services is imposed on each hospital provider in an

1 amount equal to .01525 multiplied by the hospital's outpatient
2 gross revenue, provided however: (i) for the period of July 1,
3 2020 through December 31, 2020, the assessment shall be equal
4 to 50% of the annual amount; and (ii) the amount of .01525
5 shall be retroactively adjusted by a uniform percentage to
6 generate an amount equal to 50% of the Assessment Adjustment,
7 as defined in subsection (b-7). For the period of July 1, 2020
8 through December 31, 2020 and calendar years 2021 through
9 2026, a hospital's outpatient gross revenue shall be
10 determined using the most recent data available from each
11 hospital's 2015 Medicare cost report as contained in the
12 Healthcare Cost Report Information System file, for the
13 quarter ending on March 31, 2017, without regard to any
14 subsequent adjustments or changes to such data. If a
15 hospital's 2015 Medicare cost report is not contained in the
16 Healthcare Cost Report Information System, then the Illinois
17 Department may obtain the hospital provider's outpatient
18 revenue data from any source available, including, but not
19 limited to, records maintained by the hospital provider, which
20 may be inspected at all times during business hours of the day
21 by the Illinois Department or its duly authorized agents and
22 employees. Should the change in the assessment methodology
23 above for fiscal years 2021 through calendar year 2022 not be
24 approved prior to July 1, 2020, the assessment and payments
25 under this Article in effect for fiscal year 2020 shall remain
26 in place until the new assessment is approved. If the change in

1 the assessment methodology above for July 1, 2020 through
2 December 31, 2022, is approved after June 30, 2020, it shall
3 have a retroactive effective date of July 1, 2020, subject to
4 federal approval and provided that the payments authorized
5 under Section 12A-7 have the same effective date as the new
6 assessment methodology. In giving retroactive effect to the
7 assessment approved after June 30, 2020, credit toward the new
8 assessment shall be given for any payments of the previous
9 assessment for periods after June 30, 2020. Notwithstanding
10 any other provision of this Article, for a hospital provider
11 that did not have a 2015 Medicare cost report, but paid an
12 assessment in State Fiscal Year 2020 on the basis of
13 hypothetical data, the data that was the basis for the 2020
14 assessment shall be used to calculate the assessment under
15 this paragraph until December 31, 2023. Beginning July 1, 2022
16 and through December 31, 2024, a safety-net hospital that had
17 a change of ownership in calendar year 2021, and whose
18 inpatient utilization had decreased by 90% from the prior year
19 and prior to the change of ownership, may be eligible to pay a
20 tax based on hypothetical data based on a determination of
21 financial distress by the Department.

22 (b-6)(1) As used in this Section, "ACA Assessment
23 Adjustment" means:

24 (A) For the period of July 1, 2016 through December
25 31, 2016, the product of .19125 multiplied by the sum of
26 the fee-for-service payments to hospitals as authorized

1 under Section 5A-12.5 and the adjustments authorized under
2 subsection (t) of Section 5A-12.2 to managed care
3 organizations for hospital services due and payable in the
4 month of April 2016 multiplied by 6.

5 (B) For the period of January 1, 2017 through June 30,
6 2017, the product of .19125 multiplied by the sum of the
7 fee-for-service payments to hospitals as authorized under
8 Section 5A-12.5 and the adjustments authorized under
9 subsection (t) of Section 5A-12.2 to managed care
10 organizations for hospital services due and payable in the
11 month of October 2016 multiplied by 6, except that the
12 amount calculated under this subparagraph (B) shall be
13 adjusted, either positively or negatively, to account for
14 the difference between the actual payments issued under
15 Section 5A-12.5 for the period beginning July 1, 2016
16 through December 31, 2016 and the estimated payments due
17 and payable in the month of April 2016 multiplied by 6 as
18 described in subparagraph (A).

19 (C) For the period of July 1, 2017 through December
20 31, 2017, the product of .19125 multiplied by the sum of
21 the fee-for-service payments to hospitals as authorized
22 under Section 5A-12.5 and the adjustments authorized under
23 subsection (t) of Section 5A-12.2 to managed care
24 organizations for hospital services due and payable in the
25 month of April 2017 multiplied by 6, except that the
26 amount calculated under this subparagraph (C) shall be

1 adjusted, either positively or negatively, to account for
2 the difference between the actual payments issued under
3 Section 5A-12.5 for the period beginning January 1, 2017
4 through June 30, 2017 and the estimated payments due and
5 payable in the month of October 2016 multiplied by 6 as
6 described in subparagraph (B).

7 (D) For the period of January 1, 2018 through June 30,
8 2018, the product of .19125 multiplied by the sum of the
9 fee-for-service payments to hospitals as authorized under
10 Section 5A-12.5 and the adjustments authorized under
11 subsection (t) of Section 5A-12.2 to managed care
12 organizations for hospital services due and payable in the
13 month of October 2017 multiplied by 6, except that:

14 (i) the amount calculated under this subparagraph

15 (D) shall be adjusted, either positively or
16 negatively, to account for the difference between the
17 actual payments issued under Section 5A-12.5 for the
18 period of July 1, 2017 through December 31, 2017 and
19 the estimated payments due and payable in the month of
20 April 2017 multiplied by 6 as described in
21 subparagraph (C); and

22 (ii) the amount calculated under this subparagraph
23 (D) shall be adjusted to include the product of .19125
24 multiplied by the sum of the fee-for-service payments,
25 if any, estimated to be paid to hospitals under
26 subsection (b) of Section 5A-12.5.

1 (2) The Department shall complete and apply a final
2 reconciliation of the ACA Assessment Adjustment prior to June
3 30, 2018 to account for:

4 (A) any differences between the actual payments issued
5 or scheduled to be issued prior to June 30, 2018 as
6 authorized in Section 5A-12.5 for the period of January 1,
7 2018 through June 30, 2018 and the estimated payments due
8 and payable in the month of October 2017 multiplied by 6 as
9 described in subparagraph (D); and

10 (B) any difference between the estimated
11 fee-for-service payments under subsection (b) of Section
12 5A-12.5 and the amount of such payments that are actually
13 scheduled to be paid.

14 The Department shall notify hospitals of any additional
15 amounts owed or reduction credits to be applied to the June
16 2018 ACA Assessment Adjustment. This is to be considered the
17 final reconciliation for the ACA Assessment Adjustment.

18 (3) Notwithstanding any other provision of this Section,
19 if for any reason the scheduled payments under subsection (b)
20 of Section 5A-12.5 are not issued in full by the final day of
21 the period authorized under subsection (b) of Section 5A-12.5,
22 funds collected from each hospital pursuant to subparagraph
23 (D) of paragraph (1) and pursuant to paragraph (2),
24 attributable to the scheduled payments authorized under
25 subsection (b) of Section 5A-12.5 that are not issued in full
26 by the final day of the period attributable to each payment

1 authorized under subsection (b) of Section 5A-12.5, shall be
2 refunded.

3 (4) The increases authorized under paragraph (2) of
4 subsection (a) and paragraph (2) of subsection (b-5) shall be
5 limited to the federally required State share of the total
6 payments authorized under Section 5A-12.5 if the sum of such
7 payments yields an annualized amount equal to or less than
8 \$450,000,000, or if the adjustments authorized under
9 subsection (t) of Section 5A-12.2 are found not to be
10 actuarially sound; however, this limitation shall not apply to
11 the fee-for-service payments described in subsection (b) of
12 Section 5A-12.5.

13 (b-7)(1) As used in this Section, "Assessment Adjustment"
14 means:

15 (A) For the period of July 1, 2020 through December
16 31, 2020, the product of .3853 multiplied by the total of
17 the actual payments made under subsections (c) through (k)
18 of Section 5A-12.7 attributable to the period, less the
19 total of the assessment imposed under subsections (a) and
20 (b-5) of this Section for the period.

21 (B) For each calendar quarter beginning January 1,
22 2021 through December 31, 2022, the product of .3853
23 multiplied by the total of the actual payments made under
24 subsections (c) through (k) of Section 5A-12.7
25 attributable to the period, less the total of the
26 assessment imposed under subsections (a) and (b-5) of this

1 Section for the period.

2 (C) Beginning on January 1, 2023, and each subsequent
3 July 1 and January 1, the product of .3853 multiplied by
4 the total of the actual payments made under subsections
5 (c) through (j) of Section 5A-12.7 attributable to the
6 6-month period immediately preceding the period to which
7 the adjustment applies, less the total of the assessment
8 imposed under subsections (a) and (b-5) of this Section
9 for the 6-month period immediately preceding the period to
10 which the adjustment applies.

11 (2) The Department shall calculate and notify each
12 hospital of the total Assessment Adjustment and any additional
13 assessment owed by the hospital or refund owed to the hospital
14 on either a semi-annual or annual basis. Such notice shall be
15 issued at least 30 days prior to any period in which the
16 assessment will be adjusted. Any additional assessment owed by
17 the hospital or refund owed to the hospital shall be uniformly
18 applied to the assessment owed by the hospital in monthly
19 installments for the subsequent semi-annual period or calendar
20 year. If no assessment is owed in the subsequent year, any
21 amount owed by the hospital or refund due to the hospital,
22 shall be paid in a lump sum.

23 (3) The Department shall publish all details of the
24 Assessment Adjustment calculation performed each year on its
25 website within 30 days of completing the calculation, and also
26 submit the details of the Assessment Adjustment calculation as

1 part of the Department's annual report to the General
2 Assembly.

3 (b-8) Notwithstanding any other provision of this Article,
4 the Department shall reduce the assessments imposed on each
5 hospital under subsections (a) and (b-5) by the uniform
6 percentage necessary to reduce the total assessment imposed on
7 all hospitals by an aggregate amount of \$240,000,000, with
8 such reduction being applied by June 30, 2022. The assessment
9 reduction required for each hospital under this subsection
10 shall be forever waived, forgiven, and released by the
11 Department.

12 (c) (Blank).

13 (d) Notwithstanding any of the other provisions of this
14 Section, the Department is authorized to adopt rules to reduce
15 the rate of any annual assessment imposed under this Section,
16 as authorized by Section 5-46.2 of the Illinois Administrative
17 Procedure Act.

18 (e) Notwithstanding any other provision of this Section,
19 any plan providing for an assessment on a hospital provider as
20 a permissible tax under Title XIX of the federal Social
21 Security Act and Medicaid-eligible payments to hospital
22 providers from the revenues derived from that assessment shall
23 be reviewed by the Illinois Department of Healthcare and
24 Family Services, as the Single State Medicaid Agency required
25 by federal law, to determine whether those assessments and
26 hospital provider payments meet federal Medicaid standards. If

1 the Department determines that the elements of the plan may
2 meet federal Medicaid standards and a related State Medicaid
3 Plan Amendment is prepared in a manner and form suitable for
4 submission, that State Plan Amendment shall be submitted in a
5 timely manner for review by the Centers for Medicare and
6 Medicaid Services of the United States Department of Health
7 and Human Services and subject to approval by the Centers for
8 Medicare and Medicaid Services of the United States Department
9 of Health and Human Services. No such plan shall become
10 effective without approval by the Illinois General Assembly by
11 the enactment into law of related legislation. Notwithstanding
12 any other provision of this Section, the Department is
13 authorized to adopt rules to reduce the rate of any annual
14 assessment imposed under this Section. Any such rules may be
15 adopted by the Department under Section 5-50 of the Illinois
16 Administrative Procedure Act.

17 (Source: P.A. 101-10, eff. 6-5-19; 101-650, eff. 7-7-20;
18 reenacted by P.A. 101-655, eff. 3-12-21; 102-886, eff.
19 5-17-22.)

20 ARTICLE 110.

21 Section 110-5. The Illinois Insurance Code is amended by
22 adding Section 513b7 as follows:

23 (215 ILCS 5/513b7 new)

1 Sec. 513b7. Pharmacy audits.

2 (a) As used in this Section:

3 "Audit" means any physical on-site, remote electronic, or
4 concurrent review of a pharmacist or pharmacy service
5 submitted to the pharmacy benefit manager or pharmacy benefit
6 manager affiliate by a pharmacist or pharmacy for payment.

7 "Auditing entity" means a person or company that performs
8 a pharmacy audit.

9 "Extrapolation" means the practice of inferring a
10 frequency of dollar amount of overpayments, underpayments,
11 nonvalid claims, or other errors on any portion of claims
12 submitted, based on the frequency of dollar amount of
13 overpayments, underpayments, nonvalid claims, or other errors
14 actually measured in a sample of claims.

15 "Misfill" means a prescription that was not dispensed; a
16 prescription that was dispensed but was an incorrect dose,
17 amount, or type of medication; a prescription that was
18 dispensed to the wrong person; a prescription in which the
19 prescriber denied the authorization request; or a prescription
20 in which an additional dispensing fee was charged.

21 "Pharmacy audit" means an audit conducted of any records
22 of a pharmacy for prescriptions dispensed or nonproprietary
23 drugs or pharmacist services provided by a pharmacy or
24 pharmacist to a covered person.

25 "Pharmacy record" means any record stored electronically
26 or as a hard copy by a pharmacy that relates to the provision

1 of a prescription or pharmacy services or other component of
2 pharmacist care that is included in the practice of pharmacy.

3 (b) Notwithstanding any other law, when conducting a
4 pharmacy audit, an auditing entity shall:

5 (1) not conduct an on-site audit of a pharmacy at any
6 time during the first 3 business days of a month or the
7 first 2 weeks and final 2 weeks of the calendar year or
8 during a declared State or federal public health
9 emergency;

10 (2) notify the pharmacy or its contracting agent no
11 later than 14 business days before the date of initial
12 on-site audit; the notification to the pharmacy or its
13 contracting agent shall be in writing and delivered
14 either:

15 (A) by mail or common carrier, return receipt
16 requested; or

17 (B) electronically, not including facsimile, with
18 electronic receipt confirmation and delivered during
19 normal business hours of operation, addressed to the
20 supervising pharmacist and pharmacy corporate office,
21 if applicable, at least 14 business days before the
22 date of an initial on-site audit;

23 (3) limit the audit period to 24 months after the date
24 a claim is submitted to or adjudicated by the pharmacy
25 benefit manager;

26 (4) provide in writing the list of specific

1 prescription numbers to be included in the audit 14
2 business days before the on-site audit that may or may not
3 include the final 2 digits of the prescription numbers;

4 (5) use the written and verifiable records of a
5 hospital, physician, or other authorized practitioner that
6 are transmitted by any means of communication to validate
7 the pharmacy records in accordance with State and federal
8 law;

9 (6) limit the number of prescriptions audited to no
10 more than 100 prescriptions per audit and an entity shall
11 not audit more than 200 prescriptions in any 12-month
12 period, except in cases of fraud or knowing and willful
13 misrepresentation; a refill shall not constitute a
14 separate prescription and a pharmacy shall not be audited
15 more than once every 6 months;

16 (7) provide the pharmacy or its contracting agent with
17 a copy of the preliminary audit report within 45 days
18 after the conclusion of the audit;

19 (8) be allowed to conduct a follow-up audit on site if
20 a remote or desk audit reveals the necessity for a review
21 of additional claims;

22 (9) accept invoice audits as validation invoices from
23 any wholesaler registered with the Department of Financial
24 and Professional Regulation from which the pharmacy has
25 purchased prescription drugs or, in the case of durable
26 medical equipment or sickroom supplies, invoices from an

1 authorized distributor other than a wholesaler;

2 (10) provide the pharmacy or its contracting agent
3 with the ability to provide documentation to address a
4 discrepancy or audit finding if the documentation is
5 received by the pharmacy benefit manager no later than the
6 45th day after the preliminary audit report was provided
7 to the pharmacy or its contracting agent; the pharmacy
8 benefit manager shall consider a reasonable request from
9 the pharmacy for an extension of time to submit
10 documentation to address or correct any findings in the
11 report;

12 (11) be required to provide the pharmacy or its
13 contracting agent with the final audit report no later
14 than 90 days after the initial audit report was provided
15 to the pharmacy or its contracting agent;

16 (12) conduct the audit in consultation with a
17 pharmacist in specific cases if the audit involves
18 clinical or professional judgment;

19 (13) not chargeback, recoup, or collect penalties from
20 a pharmacy until the time period to file an appeal of the
21 final pharmacy audit report has passed or the appeals
22 process has been exhausted, whichever is later, unless the
23 identified discrepancy is expected to exceed \$25,000, in
24 which case the auditing entity may withhold future
25 payments in excess of that amount until the final
26 resolution of the audit;

1 (14) not compensate the employee or contractor
2 conducting the audit based on a percentage of the amount
3 claimed or recouped pursuant to the audit;

4 (15) not use extrapolation to calculate penalties or
5 amounts to be charged back or recouped unless otherwise
6 required by federal law or regulation; any amount to be
7 charged back or recouped due to overpayment may not exceed
8 the amount the pharmacy was overpaid;

9 (16) not include dispensing fees in the calculation of
10 overpayments unless a prescription is considered a
11 misfill, the medication is not delivered to the patient,
12 the prescription is not valid, or the prescriber denies
13 authorizing the prescription; and

14 (17) conduct a pharmacy audit under the same standards
15 and parameters as conducted for other similarly situated
16 pharmacies audited by the auditing entity.

17 (c) Except as otherwise provided by State or federal law,
18 an auditing entity conducting a pharmacy audit may have access
19 to a pharmacy's previous audit report only if the report was
20 prepared by that auditing entity.

21 (d) Information collected during a pharmacy audit shall be
22 confidential by law, except that the auditing entity
23 conducting the pharmacy audit may share the information with
24 the health benefit plan for which a pharmacy audit is being
25 conducted and with any regulatory agencies and law enforcement
26 agencies as required by law.

1 (e) A pharmacy may not be subject to a chargeback or
2 recoupment for a clerical or recordkeeping error in a required
3 document or record, including a typographical error or
4 computer error, unless the pharmacy benefit manager can
5 provide proof of intent to commit fraud or such error results
6 in actual financial harm to the pharmacy benefit manager, a
7 health plan managed by the pharmacy benefit manager, or a
8 consumer.

9 (f) A pharmacy shall have the right to file a written
10 appeal of a preliminary and final pharmacy audit report in
11 accordance with the procedures established by the entity
12 conducting the pharmacy audit.

13 (g) No interest shall accrue for any party during the
14 audit period, beginning with the notice of the pharmacy audit
15 and ending with the conclusion of the appeals process.

16 (h) An auditing entity must provide a copy to the plan
17 sponsor of its claims that were included in the audit, and any
18 recouped money shall be returned to the plan sponsor, unless
19 otherwise contractually agreed upon by the plan sponsor and
20 the pharmacy benefit manager.

21 (i) The parameters of an audit must comply with
22 manufacturer listings or recommendations, unless otherwise
23 prescribed by the treating provider, and must be covered under
24 the individual's health plan, for the following:

25 (1) the day supply for eye drops must be calculated so
26 that the consumer pays only one 30-day copayment if the

1 bottle of eye drops is intended by the manufacturer to be a
2 30-day supply;

3 (2) the day supply for insulin must be calculated so
4 that the highest dose prescribed is used to determine the
5 day supply and consumer copayment; and

6 (3) the day supply for topical product must be
7 determined by the judgment of the pharmacist or treating
8 provider upon the treated area.

9 (j) This Section shall not apply to:

10 (1) audits in which suspected fraud or knowing and
11 willful misrepresentation is evidenced by a physical
12 review, review of claims data or statements, or other
13 investigative methods;

14 (2) audits of claims paid for by federally funded
15 programs not applicable to health insurance coverage
16 regulated by the Department; or

17 (3) concurrent reviews or desk audits that occur
18 within 3 business days after transmission of a claim and
19 in which no chargeback or recoupment is demanded.

20 ARTICLE 115.

21 Section 115-5. The Illinois Public Aid Code is amended by
22 changing Section 5-30.11 as follows:

23 (305 ILCS 5/5-30.11)

1 Sec. 5-30.11. Treatment of autism spectrum disorder.
2 Treatment of autism spectrum disorder through applied behavior
3 analysis shall be covered under the medical assistance program
4 under this Article for children with a diagnosis of autism
5 spectrum disorder when (1) ordered by:~~(1)~~ a physician
6 licensed to practice medicine in all its branches or a
7 psychologist licensed by the Department of Financial and
8 Professional Regulation and (2) ~~and rendered by a licensed or~~
9 ~~certified health care professional with expertise in applied~~
10 ~~behavior analysis; or (2) when~~ evaluated ~~and treated~~ by a
11 behavior analyst as recognized by the Department or licensed
12 by the Department of Financial and Professional Regulation to
13 practice applied behavior analysis in this State. Such
14 coverage may be limited to age ranges based on evidence-based
15 best practices. Appropriate State plan amendments as well as
16 rules regarding provision of services and providers will be
17 submitted by September 1, 2019. Pursuant to the flexibilities
18 allowed by the federal Centers for Medicare and Medicaid
19 Services to Illinois under the Medical Assistance Program, the
20 Department shall enroll and reimburse qualified staff to
21 perform applied behavior analysis services in advance of
22 Illinois licensure activities performed by the Department of
23 Financial and Professional Regulation. These services shall be
24 covered if they are provided in a home or community setting or
25 in an office-based setting. The Department may conduct annual
26 on-site reviews of the services authorized under this Section.

1 Provider enrollment shall occur no later than September 1,
2 2023.

3 (Source: P.A. 101-10, eff. 6-5-19; 102-558, eff. 8-20-21;
4 102-953, eff. 5-27-22.)

5 ARTICLE 120.

6 Section 120-5. The Illinois Public Aid Code is amended by
7 adding Section 5-5a.1 as follows:

8 (305 ILCS 5/5-5a.1 new)

9 Sec. 5-5a.1. Telehealth services for persons with
10 intellectual and developmental disabilities. The Department
11 shall file an amendment to the Home and Community-Based
12 Services Waiver Program for Adults with Developmental
13 Disabilities authorized under Section 1915(c) of the Social
14 Security Act to incorporate telehealth services administered
15 by a provider of telehealth services that demonstrates
16 knowledge and experience in providing medical and emergency
17 services for persons with intellectual and developmental
18 disabilities. The Department shall pay administrative fees
19 associated with implementing telehealth services for all
20 persons with intellectual and developmental disabilities who
21 are receiving services under the Home and Community-Based
22 Services Waiver Program for Adults with Developmental
23 Disabilities.

1 ARTICLE 125.

2 Section 125-5. The Illinois Public Aid Code is amended by
3 adding Section 5-48 as follows:

4 (305 ILCS 5/5-48 new)

5 Sec. 5-48. Increasing behavioral health service capacity
6 in federally qualified health centers. The Department of
7 Healthcare and Family Services shall develop policies and
8 procedures with the goal of increasing the capacity of
9 behavioral health services provided by federally qualified
10 health centers as defined in Section 1905(1)(2)(B) of the
11 federal Social Security Act. Subject to federal approval, the
12 Department shall develop, no later than January 1, 2024,
13 billing policies that provide reimbursement to federally
14 qualified health centers for services rendered by
15 graduate-level, sub-clinical behavioral health professionals
16 who deliver care under the supervision of a fully licensed
17 behavioral health clinician who is licensed as a clinical
18 social worker, clinical professional counselor, marriage and
19 family therapist, or clinical psychologist.

20 To be eligible for reimbursement as provided for in this
21 Section, a graduate-level, sub-clinical professional must meet
22 the educational requirements set forth by the Department of
23 Financial and Professional Regulation for licensed clinical

1 social workers, licensed clinical professional counselors,
2 licensed marriage and family therapists, or licensed clinical
3 psychologists. An individual seeking to fulfill post-degree
4 experience requirements in order to qualify for licensing as a
5 clinical social worker, clinical professional counselor,
6 marriage and family therapist, or clinical psychologist shall
7 also be eligible for reimbursement under this Section so long
8 as the individual is in compliance with all applicable laws
9 and regulations regarding supervision, including, but not
10 limited to, the requirement that the supervised experience be
11 under the order, control, and full professional responsibility
12 of the individual's supervisor or that the individual is
13 designated by a title that clearly indicates training status.

14 The Department shall work with a trade association
15 representing a majority of federally qualified health centers
16 operating in Illinois to develop the policies and procedures
17 required under this Section.

18 ARTICLE 130.

19 Section 130-5. The Illinois Insurance Code is amended by
20 changing Section 363 as follows:

21 (215 ILCS 5/363) (from Ch. 73, par. 975)

22 Sec. 363. Medicare supplement policies; minimum standards.

23 (1) Except as otherwise specifically provided therein,

1 this Section and Section 363a of this Code shall apply to:

2 (a) all Medicare supplement policies and subscriber
3 contracts delivered or issued for delivery in this State
4 on and after January 1, 1989; and

5 (b) all certificates issued under group Medicare
6 supplement policies or subscriber contracts, which
7 certificates are issued or issued for delivery in this
8 State on and after January 1, 1989.

9 This Section shall not apply to "Accident Only" or
10 "Specified Disease" types of policies. The provisions of this
11 Section are not intended to prohibit or apply to policies or
12 health care benefit plans, including group conversion
13 policies, provided to Medicare eligible persons, which
14 policies or plans are not marketed or purported or held to be
15 Medicare supplement policies or benefit plans.

16 (2) For the purposes of this Section and Section 363a, the
17 following terms have the following meanings:

18 (a) "Applicant" means:

19 (i) in the case of individual Medicare supplement
20 policy, the person who seeks to contract for insurance
21 benefits, and

22 (ii) in the case of a group Medicare policy or
23 subscriber contract, the proposed certificate holder.

24 (b) "Certificate" means any certificate delivered or
25 issued for delivery in this State under a group Medicare
26 supplement policy.

1 (c) "Medicare supplement policy" means an individual
2 policy of accident and health insurance, as defined in
3 paragraph (a) of subsection (2) of Section 355a of this
4 Code, or a group policy or certificate delivered or issued
5 for delivery in this State by an insurer, fraternal
6 benefit society, voluntary health service plan, or health
7 maintenance organization, other than a policy issued
8 pursuant to a contract under Section 1876 of the federal
9 Social Security Act (42 U.S.C. Section 1395 et seq.) or a
10 policy issued under a demonstration project specified in
11 42 U.S.C. Section 1395ss(g)(1), or any similar
12 organization, that is advertised, marketed, or designed
13 primarily as a supplement to reimbursements under Medicare
14 for the hospital, medical, or surgical expenses of persons
15 eligible for Medicare.

16 (d) "Issuer" includes insurance companies, fraternal
17 benefit societies, voluntary health service plans, health
18 maintenance organizations, or any other entity providing
19 Medicare supplement insurance, unless the context clearly
20 indicates otherwise.

21 (e) "Medicare" means the Health Insurance for the Aged
22 Act, Title XVIII of the Social Security Amendments of
23 1965.

24 (3) No Medicare supplement insurance policy, contract, or
25 certificate, that provides benefits that duplicate benefits
26 provided by Medicare, shall be issued or issued for delivery

1 in this State after December 31, 1988. No such policy,
2 contract, or certificate shall provide lesser benefits than
3 those required under this Section or the existing Medicare
4 Supplement Minimum Standards Regulation, except where
5 duplication of Medicare benefits would result.

6 (4) Medicare supplement policies or certificates shall
7 have a notice prominently printed on the first page of the
8 policy or attached thereto stating in substance that the
9 policyholder or certificate holder shall have the right to
10 return the policy or certificate within 30 days of its
11 delivery and to have the premium refunded directly to him or
12 her in a timely manner if, after examination of the policy or
13 certificate, the insured person is not satisfied for any
14 reason.

15 (5) A Medicare supplement policy or certificate may not
16 deny a claim for losses incurred more than 6 months from the
17 effective date of coverage for a preexisting condition. The
18 policy may not define a preexisting condition more
19 restrictively than a condition for which medical advice was
20 given or treatment was recommended by or received from a
21 physician within 6 months before the effective date of
22 coverage.

23 (6) An issuer of a Medicare supplement policy shall:

24 (a) not deny coverage to an applicant under 65 years
25 of age who meets any of the following criteria:

26 (i) becomes eligible for Medicare by reason of

1 disability if the person makes application for a
2 Medicare supplement policy within 6 months of the
3 first day on which the person enrolls for benefits
4 under Medicare Part B; for a person who is
5 retroactively enrolled in Medicare Part B due to a
6 retroactive eligibility decision made by the Social
7 Security Administration, the application must be
8 submitted within a 6-month period beginning with the
9 month in which the person received notice of
10 retroactive eligibility to enroll;

11 (ii) has Medicare and an employer group health
12 plan (either primary or secondary to Medicare) that
13 terminates or ceases to provide all such supplemental
14 health benefits;

15 (iii) is insured by a Medicare Advantage plan that
16 includes a Health Maintenance Organization, a
17 Preferred Provider Organization, and a Private
18 Fee-For-Service or Medicare Select plan and the
19 applicant moves out of the plan's service area; the
20 insurer goes out of business, withdraws from the
21 market, or has its Medicare contract terminated; or
22 the plan violates its contract provisions or is
23 misrepresented in its marketing; or

24 (iv) is insured by a Medicare supplement policy
25 and the insurer goes out of business, withdraws from
26 the market, or the insurance company or agents

1 misrepresent the plan and the applicant is without
2 coverage;

3 (b) make available to persons eligible for Medicare by
4 reason of disability each type of Medicare supplement
5 policy the issuer makes available to persons eligible for
6 Medicare by reason of age;

7 (c) not charge individuals who become eligible for
8 Medicare by reason of disability and who are under the age
9 of 65 premium rates for any medical supplemental insurance
10 benefit plan offered by the issuer that exceed the
11 issuer's highest rate on the current rate schedule filed
12 with the Division of Insurance for that plan to
13 individuals who are age 65 or older; and

14 (d) provide the rights granted by items (a) through
15 (d), for 6 months after the effective date of this
16 amendatory Act of the 95th General Assembly, to any person
17 who had enrolled for benefits under Medicare Part B prior
18 to this amendatory Act of the 95th General Assembly who
19 otherwise would have been eligible for coverage under item
20 (a).

21 (7) The Director shall issue reasonable rules and
22 regulations for the following purposes:

23 (a) To establish specific standards for policy
24 provisions of Medicare policies and certificates. The
25 standards shall be in accordance with the requirements of
26 this Code. No requirement of this Code relating to minimum

1 required policy benefits, other than the minimum standards
2 contained in this Section and Section 363a, shall apply to
3 Medicare supplement policies and certificates. The
4 standards may cover, but are not limited to the following:

5 (A) Terms of renewability.

6 (B) Initial and subsequent terms of eligibility.

7 (C) Non-duplication of coverage.

8 (D) Probationary and elimination periods.

9 (E) Benefit limitations, exceptions and
10 reductions.

11 (F) Requirements for replacement.

12 (G) Recurrent conditions.

13 (H) Definition of terms.

14 (I) Requirements for issuing rebates or credits to
15 policyholders if the policy's loss ratio does not
16 comply with subsection (7) of Section 363a.

17 (J) Uniform methodology for the calculating and
18 reporting of loss ratio information.

19 (K) Assuring public access to loss ratio
20 information of an issuer of Medicare supplement
21 insurance.

22 (L) Establishing a process for approving or
23 disapproving proposed premium increases.

24 (M) Establishing a policy for holding public
25 hearings prior to approval of premium increases.

26 (N) Establishing standards for Medicare Select

1 policies.

2 (O) Prohibited policy provisions not otherwise
3 specifically authorized by statute that, in the
4 opinion of the Director, are unjust, unfair, or
5 unfairly discriminatory to any person insured or
6 proposed for coverage under a medicare supplement
7 policy or certificate.

8 (b) To establish minimum standards for benefits and
9 claims payments, marketing practices, compensation
10 arrangements, and reporting practices for Medicare
11 supplement policies.

12 (c) To implement transitional requirements of Medicare
13 supplement insurance benefits and premiums of Medicare
14 supplement policies and certificates to conform to
15 Medicare program revisions.

16 (8) If an individual is at least 65 years of age but no
17 more than 75 years of age and has an existing Medicare
18 supplement policy, the individual is entitled to an annual
19 open enrollment period lasting 45 days, commencing with the
20 individual's birthday, and the individual may purchase any
21 Medicare supplement policy with the same issuer that offers
22 benefits equal to or lesser than those provided by the
23 previous coverage. During this open enrollment period, an
24 issuer of a Medicare supplement policy shall not deny or
25 condition the issuance or effectiveness of Medicare
26 supplemental coverage, nor discriminate in the pricing of

1 coverage, because of health status, claims experience, receipt
2 of health care, or a medical condition of the individual. An
3 issuer shall provide notice of this annual open enrollment
4 period for eligible Medicare supplement policyholders at the
5 time that the application is made for a Medicare supplement
6 policy or certificate. The notice shall be in a form that may
7 be prescribed by the Department.

8 (9) Without limiting an individual's eligibility under
9 Department rules implementing 42 U.S.C. 1395ss(s)(2)(A), for
10 at least 63 days after an applicant loses benefits under the
11 State's medical assistance program under Article V of the
12 Illinois Public Aid Code, an issuer shall not deny or
13 condition the issuance or effectiveness of any Medicare
14 supplement policy or certificate that is offered and is
15 available for issuance to new enrollees by the issuer; shall
16 not discriminate in the pricing of such a Medicare supplement
17 policy because of health status, claims experience, receipt of
18 health care, or medical condition; and shall not include a
19 policy provision that imposes an exclusion of benefits based
20 on a preexisting condition under such a Medicare supplement
21 policy if the individual:

22 (a) is enrolled for Medicare Part B;

23 (b) was enrolled in the State's medical assistance
24 program during the COVID-19 Public Health Emergency
25 described in Section 5-1.5 of the Illinois Public Aid
26 Code;

1 (c) was terminated or disenrolled from the State's
2 medical assistance program after the COVID-19 Public
3 Health Emergency with the loss of benefits taking effect
4 on, after, or no more than 63 days before the end of
5 either, as applicable:

6 (A) the individual's Medicare supplement open
7 enrollment period described in Department rules
8 implementing 42 U.S.C. 1395ss(s) (2) (A); or

9 (B) the 6-month period described in Section
10 363(6) (a) (i) of this Code; and

11 (d) submits evidence of the date of termination of
12 benefits under the State's medical assistance program with
13 the application for a Medicare supplement policy or
14 certificate.

15 (10) Each Medicare supplement policy and certificate
16 available from an insurer on and after the effective date of
17 this amendatory Act of the 103rd General Assembly shall be
18 made available to all applicants who qualify under
19 subparagraph (i) of paragraph (a) of subsection (6) or
20 Department rules implementing 42 U.S.C. 1395ss(s) (2) (A)
21 without regard to age or applicability of a Medicare Part B
22 late enrollment penalty.

23 (Source: P.A. 102-142, eff. 1-1-22.)

1 Section 135-5. The Illinois Public Aid Code is amended by
2 adding Section 5-49 as follows:

3 (305 ILCS 5/5-49 new)

4 Sec. 5-49. Long-acting reversible contraception. Subject
5 to federal approval, the Department shall adopt policies and
6 rates for long-acting reversible contraception by January 1,
7 2024 to ensure that reimbursement is not reduced by 4.4% below
8 list price. The Department shall submit any necessary
9 application to the federal Centers for Medicare and Medicaid
10 Services for the purposes of implementing such policies and
11 rates.

12 ARTICLE 140.

13 Section 140-5. The Illinois Public Aid Code is amended by
14 changing Section 5-30.8 as follows:

15 (305 ILCS 5/5-30.8)

16 Sec. 5-30.8. Managed care organization rate transparency.

17 (a) For the establishment of managed care organization
18 (MCO) capitation base rate payments from the State, including,
19 but not limited to: (i) hospital fee schedule reforms and
20 updates, (ii) rates related to a single State-mandated
21 preferred drug list, (iii) rate updates related to the State's
22 preferred drug list, (iv) inclusion of coverage for children

1 with special needs, (v) inclusion of coverage for children
2 within the child welfare system, (vi) annual MCO capitation
3 rates, and (vii) any retroactive provider fee schedule
4 adjustments or other changes required by legislation or other
5 actions, the Department of Healthcare and Family Services
6 shall implement a capitation base rate setting process
7 beginning on July 27, 2018 (the effective date of Public Act
8 100-646) which shall include all of the following elements of
9 transparency:

10 (1) The Department shall include participating MCOs
11 and a statewide trade association representing a majority
12 of participating MCOs in meetings to discuss the impact to
13 base capitation rates as a result of any new or updated
14 hospital fee schedules or other provider fee schedules.
15 Additionally, the Department shall share any data or
16 reports used to develop MCO capitation rates with
17 participating MCOs. This data shall be comprehensive
18 enough for MCO actuaries to recreate and verify the
19 accuracy of the capitation base rate build-up.

20 (2) The Department shall not limit the number of
21 experts that each MCO is allowed to bring to the draft
22 capitation base rate meeting or the final capitation base
23 rate review meeting. Draft and final capitation base rate
24 review meetings shall be held in at least 2 locations.

25 (3) The Department and its contracted actuary shall
26 meet with all participating MCOs simultaneously and

1 together along with consulting actuaries contracted with
2 statewide trade association representing a majority of
3 Medicaid health plans at the request of the plans.
4 Participating MCOs shall additionally, at their request,
5 be granted individual capitation rate development meetings
6 with the Department.

7 (4) (Blank). ~~Any quality incentive or other incentive~~
8 ~~withholding of any portion of the actuarially certified~~
9 ~~capitation rates must be budget neutral. The entirety of~~
10 ~~any aggregate withheld amounts must be returned to the~~
11 ~~MCOs in proportion to their performance on the relevant~~
12 ~~performance metric. No amounts shall be returned to the~~
13 ~~Department if all performance measures are not achieved to~~
14 ~~the extent allowable by federal law and regulations.~~

15 (4.5) Effective for calendar year 2024, a quality
16 withhold program may be established by the Department for
17 the HealthChoice Illinois Managed Care Program or any
18 successor program. If such program withholds a portion of
19 the actuarially certified capitation rates, the program
20 must meet the following criteria: (i) benchmarks must be
21 discussed publicly, based on predetermined quality
22 standards that align with the Department's federally
23 approved quality strategy, and set by publication on the
24 Department's website at least 4 months prior to the start
25 of the calendar year; (ii) incentive measures and
26 benchmarks must be reasonable and attainable within the

1 measurement year; and (iii) no less than 75% of the
2 metrics shall be tied to nationally recognized measures.
3 Any non-nationally recognized measures shall be in the
4 reporting category for at least 2 years of experience and
5 evaluation for consistency among MCOs prior to setting a
6 performance baseline. The Department shall provide MCOs
7 with biannual industry average data on the quality
8 withhold measures. If all the money withheld is not earned
9 back by individual MCOs, the Department shall reallocate
10 unearned funds among the MCOs in one or both of the
11 following manners: based upon their quality performance or
12 for quality and equity improvement projects. Nothing in
13 this paragraph prohibits the Department and the MCOs from
14 establishing any other quality performance program.

15 (5) Upon request, the Department shall provide written
16 responses to questions regarding MCO capitation base
17 rates, the capitation base development methodology, and
18 MCO capitation rate data, and all other requests regarding
19 capitation rates from MCOs. Upon request, the Department
20 shall also provide to the MCOs materials used in
21 incorporating provider fee schedules into base capitation
22 rates.

23 (b) For the development of capitation base rates for new
24 capitation rate years:

25 (1) The Department shall take into account emerging
26 experience in the development of the annual MCO capitation

1 base rates, including, but not limited to, current-year
2 cost and utilization trends observed by MCOs in an
3 actuarially sound manner and in accordance with federal
4 law and regulations.

5 (2) No later than January 1 of each year, the
6 Department shall release an agreed upon annual calendar
7 that outlines dates for capitation rate setting meetings
8 for that year. The calendar shall include at least the
9 following meetings and deadlines:

10 (A) An initial meeting for the Department to
11 review MCO data and draft rate assumptions to be used
12 in the development of capitation base rates for the
13 following year.

14 (B) A draft rate meeting after the Department
15 provides the MCOs with the draft capitation base rates
16 to discuss, review, and seek feedback regarding the
17 draft capitation base rates.

18 (3) Prior to the submission of final capitation rates
19 to the federal Centers for Medicare and Medicaid Services,
20 the Department shall provide the MCOs with a final
21 actuarial report including the final capitation base rates
22 for the following year and subsequently conduct a final
23 capitation base review meeting. Final capitation rates
24 shall be marked final.

25 (c) For the development of capitation base rates
26 reflecting policy changes:

1 (1) Unless contrary to federal law and regulation, the
2 Department must provide notice to MCOs of any significant
3 operational policy change no later than 60 days prior to
4 the effective date of an operational policy change in
5 order to give MCOs time to prepare for and implement the
6 operational policy change and to ensure that the quality
7 and delivery of enrollee health care is not disrupted.
8 "Operational policy change" means a change to operational
9 requirements such as reporting formats, encounter
10 submission definitional changes, or required provider
11 interfaces made at the sole discretion of the Department
12 and not required by legislation with a retroactive
13 effective date. Nothing in this Section shall be construed
14 as a requirement to delay or prohibit implementation of
15 policy changes that impact enrollee benefits as determined
16 in the sole discretion of the Department.

17 (2) No later than 60 days after the effective date of
18 the policy change or program implementation, the
19 Department shall meet with the MCOs regarding the initial
20 data collection needed to establish capitation base rates
21 for the policy change. Additionally, the Department shall
22 share with the participating MCOs what other data is
23 needed to estimate the change and the processes for
24 collection of that data that shall be utilized to develop
25 capitation base rates.

26 (3) No later than 60 days after the effective date of

1 the policy change or program implementation, the
2 Department shall meet with MCOs to review data and the
3 Department's written draft assumptions to be used in
4 development of capitation base rates for the policy
5 change, and shall provide opportunities for questions to
6 be asked and answered.

7 (4) No later than 60 days after the effective date of
8 the policy change or program implementation, the
9 Department shall provide the MCOs with draft capitation
10 base rates and shall also conduct a draft capitation base
11 rate meeting with MCOs to discuss, review, and seek
12 feedback regarding the draft capitation base rates.

13 (d) For the development of capitation base rates for
14 retroactive policy or fee schedule changes:

15 (1) The Department shall meet with the MCOs regarding
16 the initial data collection needed to establish capitation
17 base rates for the policy change. Additionally, the
18 Department shall share with the participating MCOs what
19 other data is needed to estimate the change and the
20 processes for collection of the data that shall be
21 utilized to develop capitation base rates.

22 (2) The Department shall meet with MCOs to review data
23 and the Department's written draft assumptions to be used
24 in development of capitation base rates for the policy
25 change. The Department shall provide opportunities for
26 questions to be asked and answered.

1 license. The Department shall adopt rules establishing
2 qualifications and application fees for the limited licensure
3 of international medical graduate physicians and may adopt
4 other rules as may be necessary for the implementation of this
5 Section. The Department shall adopt rules that provide a
6 pathway to full licensure for limited license holders after
7 the licensee successfully completes a supervision period and
8 satisfies other qualifications as established by the
9 Department.

10 (225 ILCS 60/54.2)

11 (Section scheduled to be repealed on January 1, 2027)

12 Sec. 54.2. Physician delegation of authority.

13 (a) Nothing in this Act shall be construed to limit the
14 delegation of patient care tasks or duties by a physician, to a
15 licensed practical nurse, a registered professional nurse, or
16 other licensed person practicing within the scope of his or
17 her individual licensing Act. Delegation by a physician
18 licensed to practice medicine in all its branches to physician
19 assistants or advanced practice registered nurses is also
20 addressed in Section 54.5 of this Act. No physician may
21 delegate any patient care task or duty that is statutorily or
22 by rule mandated to be performed by a physician.

23 (b) In an office or practice setting and within a
24 physician-patient relationship, a physician may delegate
25 patient care tasks or duties to an unlicensed person who

1 possesses appropriate training and experience provided a
2 health care professional, who is practicing within the scope
3 of such licensed professional's individual licensing Act, is
4 on site to provide assistance.

5 (c) Any such patient care task or duty delegated to a
6 licensed or unlicensed person must be within the scope of
7 practice, education, training, or experience of the delegating
8 physician and within the context of a physician-patient
9 relationship.

10 (d) Nothing in this Section shall be construed to affect
11 referrals for professional services required by law.

12 (e) The Department shall have the authority to promulgate
13 rules concerning a physician's delegation, including but not
14 limited to, the use of light emitting devices for patient care
15 or treatment.

16 (f) Nothing in this Act shall be construed to limit the
17 method of delegation that may be authorized by any means,
18 including, but not limited to, oral, written, electronic,
19 standing orders, protocols, guidelines, or verbal orders.

20 (g) A physician licensed to practice medicine in all of
21 its branches under this Act may delegate any and all authority
22 prescribed to him or her by law to international medical
23 graduate physicians, so long as the tasks or duties are within
24 the scope of practice, education, training, or experience of
25 the delegating physician who is on site to provide assistance.
26 An international medical graduate working in Illinois pursuant

1 to this subsection is subject to all statutory and regulatory
2 requirements of this Act, as applicable, relating to the
3 standards of care. An international medical graduate physician
4 is limited to providing treatment under the supervision of a
5 physician licensed to practice medicine in all of its
6 branches. The supervising physician or employer must keep
7 record of and make available upon request by the Department
8 the following: (1) evidence of education certified by the
9 Educational Commission for Foreign Medical Graduates; (2)
10 evidence of passage of Step 1, Step 2 Clinical Knowledge, and
11 Step 3 of the United States Medical Licensing Examination as
12 required by this Act; and (3) evidence of an unencumbered
13 license from another country. This subsection does not apply
14 to any international medical graduate whose license as a
15 physician is revoked, suspended, or otherwise encumbered. This
16 subsection is inoperative upon the adoption of rules
17 implementing Section 15.5.

18 (Source: P.A. 103-1, eff. 4-27-23.)

19 ARTICLE 150.

20 Section 150-5. The Illinois Administrative Procedure Act
21 is amended by adding Section 5-45.37 as follows:

22 (5 ILCS 100/5-45.37 new)

23 Sec. 5-45.37. Emergency rulemaking; medical services for

1 certain noncitizens. To provide for the expeditious and
2 effective ongoing implementation of Section 12-4.35 of the
3 Illinois Public Aid Code, emergency rules implementing Section
4 12-4.35 of the Illinois Public Aid Code may be adopted in
5 accordance with Section 5-45 by the Department of Healthcare
6 and Family Services, except that the limitation on the number
7 of emergency rules that may be adopted in a 24-month period
8 shall not apply. The adoption of emergency rules authorized by
9 Section 5-45 and this Section is deemed to be necessary for the
10 public interest, safety, and welfare.

11 This Section is repealed one year after the effective date
12 of this amendatory Act of the 103rd General Assembly.

13 Section 150-10. The Illinois Public Aid Code is amended by
14 changing Section 12-4.35 as follows:

15 (305 ILCS 5/12-4.35)

16 Sec. 12-4.35. Medical services for certain noncitizens.

17 (a) Notwithstanding Section 1-11 of this Code or Section
18 20(a) of the Children's Health Insurance Program Act, the
19 Department of Healthcare and Family Services may provide
20 medical services to noncitizens who have not yet attained 19
21 years of age and who are not eligible for medical assistance
22 under Article V of this Code or under the Children's Health
23 Insurance Program created by the Children's Health Insurance
24 Program Act due to their not meeting the otherwise applicable

1 provisions of Section 1-11 of this Code or Section 20(a) of the
2 Children's Health Insurance Program Act. The medical services
3 available, standards for eligibility, and other conditions of
4 participation under this Section shall be established by rule
5 by the Department; however, any such rule shall be at least as
6 restrictive as the rules for medical assistance under Article
7 V of this Code or the Children's Health Insurance Program
8 created by the Children's Health Insurance Program Act.

9 (a-5) Notwithstanding Section 1-11 of this Code, the
10 Department of Healthcare and Family Services may provide
11 medical assistance in accordance with Article V of this Code
12 to noncitizens over the age of 65 years of age who are not
13 eligible for medical assistance under Article V of this Code
14 due to their not meeting the otherwise applicable provisions
15 of Section 1-11 of this Code, whose income is at or below 100%
16 of the federal poverty level after deducting the costs of
17 medical or other remedial care, and who would otherwise meet
18 the eligibility requirements in Section 5-2 of this Code. The
19 medical services available, standards for eligibility, and
20 other conditions of participation under this Section shall be
21 established by rule by the Department; however, any such rule
22 shall be at least as restrictive as the rules for medical
23 assistance under Article V of this Code.

24 (a-6) By May 30, 2022, notwithstanding Section 1-11 of
25 this Code, the Department of Healthcare and Family Services
26 may provide medical services to noncitizens 55 years of age

1 through 64 years of age who (i) are not eligible for medical
2 assistance under Article V of this Code due to their not
3 meeting the otherwise applicable provisions of Section 1-11 of
4 this Code and (ii) have income at or below 133% of the federal
5 poverty level plus 5% for the applicable family size as
6 determined under applicable federal law and regulations.
7 Persons eligible for medical services under Public Act 102-16
8 shall receive benefits identical to the benefits provided
9 under the Health Benefits Service Package as that term is
10 defined in subsection (m) of Section 5-1.1 of this Code.

11 (a-7) By July 1, 2022, notwithstanding Section 1-11 of
12 this Code, the Department of Healthcare and Family Services
13 may provide medical services to noncitizens 42 years of age
14 through 54 years of age who (i) are not eligible for medical
15 assistance under Article V of this Code due to their not
16 meeting the otherwise applicable provisions of Section 1-11 of
17 this Code and (ii) have income at or below 133% of the federal
18 poverty level plus 5% for the applicable family size as
19 determined under applicable federal law and regulations. The
20 medical services available, standards for eligibility, and
21 other conditions of participation under this Section shall be
22 established by rule by the Department; however, any such rule
23 shall be at least as restrictive as the rules for medical
24 assistance under Article V of this Code. In order to provide
25 for the timely and expeditious implementation of this
26 subsection, the Department may adopt rules necessary to

1 establish and implement this subsection through the use of
2 emergency rulemaking in accordance with Section 5-45 of the
3 Illinois Administrative Procedure Act. For purposes of the
4 Illinois Administrative Procedure Act, the General Assembly
5 finds that the adoption of rules to implement this subsection
6 is deemed necessary for the public interest, safety, and
7 welfare.

8 (a-10) Notwithstanding the provisions of Section 1-11, the
9 Department shall cover immunosuppressive drugs and related
10 services associated with post-kidney transplant management,
11 excluding long-term care costs, for noncitizens who: (i) are
12 not eligible for comprehensive medical benefits; (ii) meet the
13 residency requirements of Section 5-3; and (iii) would meet
14 the financial eligibility requirements of Section 5-2.

15 (b) The Department is authorized to take any action that
16 would not otherwise be prohibited by applicable law,
17 including, without limitation, cessation or limitation of
18 enrollment, reduction of available medical services, and
19 changing standards for eligibility, that is deemed necessary
20 by the Department during a State fiscal year to assure that
21 payments under this Section do not exceed available funds.

22 (c) (Blank).

23 (d) (Blank).

24 (e) In order to provide for the expeditious and effective
25 ongoing implementation of this Section, the Department may
26 adopt rules through the use of emergency rulemaking in

1 accordance with Section 5-45 of the Illinois Administrative
2 Procedure Act, except that the limitation on the number of
3 emergency rules that may be adopted in a 24-month period shall
4 not apply. For purposes of the Illinois Administrative
5 Procedure Act, the General Assembly finds that the adoption of
6 rules to implement this Section is deemed necessary for the
7 public interest, safety, and welfare. This subsection (e) is
8 inoperative on and after July 1, 2025.

9 (Source: P.A. 101-636, eff. 6-10-20; 102-16, eff. 6-17-21;
10 102-43, Article 25, Section 25-15, eff. 7-6-21; 102-43,
11 Article 45, Section 45-5, eff. 7-6-21; 102-813, eff. 5-13-22;
12 102-1037, eff. 6-2-22.)

13 ARTICLE 999.

14 Section 999-99. Effective date. This Article and Articles
15 1, 5, 10, 145, and 150 take effect upon becoming law and
16 Articles 65, 115, 120, and 135 take effect July 1, 2023."