

1 AN ACT concerning public aid.

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

4 ARTICLE 5.

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

7 (305 ILCS 5/5-5)

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

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

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

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

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

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

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

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

26 Upon receipt of federal approval of an amendment to the

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

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

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

26 (2) eyeglasses prescribed by a physician skilled in

1 the diseases of the eye, or by an optometrist, whichever  
2 the person may select.

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

26 The Department shall not impose a deductible, coinsurance,

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

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

12 For purposes of this Section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 The Illinois Department, in cooperation with the

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

1 organizations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

1 dental hygienist, as defined under the Illinois Dental  
2 Practice Act, working under the general supervision of a  
3 dentist and employed by a federally qualified health center.

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

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

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

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

11          Notwithstanding any other provision of this Code, the  
12          medical assistance program shall, subject to appropriation and  
13          federal approval, reimburse hospitals for costs associated  
14          with a newborn screening test for the presence of  
15          metachromatic leukodystrophy, as required under the Newborn  
16          Metabolic Screening Act, at a rate not less than the fee  
17          charged by the Department of Public Health. The Department  
18          shall seek federal approval before the implementation of the  
19          newborn screening test fees by the Department of Public  
20          Health.

21          Notwithstanding any other provision of this Code,  
22          beginning on January 1, 2024, subject to federal approval,  
23          cognitive assessment and care planning services provided to a  
24          person who experiences signs or symptoms of cognitive  
25          impairment, as defined by the Diagnostic and Statistical  
26          Manual of Mental Disorders, Fifth Edition, shall be covered

1 under the medical assistance program for persons who are  
2 otherwise eligible for medical assistance under this Article.

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

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

21 ARTICLE 10.

22 Section 10-5. The Illinois Public Aid Code is amended by  
23 adding Section 5-5.05h as follows:

1 (305 ILCS 5/5-5.05h new)

2 Sec. 5-5.05h. Reimbursement rates for psychiatric  
3 evaluations and medication monitoring. Subject to federal  
4 approval, for dates of service on and after January 1, 2025,  
5 the Department shall make a one-time adjustment to the add-on  
6 rates for services delivered by physicians who are  
7 board-certified in psychiatry and advanced practice registered  
8 nurses who hold a current certification in psychiatric and  
9 mental health nursing. The one-time adjustment shall increase  
10 the add-on rates so that the sum of the Department's base per  
11 service unit rate plus the rate add-on is no less than \$264.42  
12 per hour adjusted for time and intensity as determined by the  
13 work relative value units in the 2024 national Medicare  
14 physician fee schedule, indexed to 60 minutes of individual  
15 psychotherapy.

16 ARTICLE 15.

17 Section 15-5. The Illinois Public Aid Code is amended by  
18 changing Section 5-5.01a as follows:

19 (305 ILCS 5/5-5.01a)

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

21 (a) The Department shall establish and provide oversight  
22 for a program of supportive living facilities that seek to  
23 promote resident independence, dignity, respect, and

1 well-being in the most cost-effective manner.

2 A supportive living facility is (i) a free-standing  
3 facility or (ii) a distinct physical and operational entity  
4 within a mixed-use building that meets the criteria  
5 established in subsection (d). A supportive living facility  
6 integrates housing with health, personal care, and supportive  
7 services and is a designated setting that offers residents  
8 their own separate, private, and distinct living units.

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

13 (b) Beginning July 1, 2014, subject to federal approval,  
14 the Medicaid rates for supportive living facilities shall be  
15 equal to the supportive living facility Medicaid rate  
16 effective on June 30, 2014 increased by 8.85%. Once the  
17 assessment imposed at Article V-G of this Code is determined  
18 to be a permissible tax under Title XIX of the Social Security  
19 Act, the Department shall increase the Medicaid rates for  
20 supportive living facilities effective on July 1, 2014 by  
21 9.09%. The Department shall apply this increase retroactively  
22 to coincide with the imposition of the assessment in Article  
23 V-G of this Code in accordance with the approval for federal  
24 financial participation by the Centers for Medicare and  
25 Medicaid Services.

26 The Medicaid rates for supportive living facilities

1 effective on July 1, 2017 must be equal to the rates in effect  
2 for supportive living facilities on June 30, 2017 increased by  
3 2.8%.

4 The Medicaid rates for supportive living facilities  
5 effective on July 1, 2018 must be equal to the rates in effect  
6 for supportive living facilities on June 30, 2018.

7 Subject to federal approval, the Medicaid rates for  
8 supportive living services on and after July 1, 2019 must be at  
9 least 54.3% of the average total nursing facility services per  
10 diem for the geographic areas defined by the Department while  
11 maintaining the rate differential for dementia care and must  
12 be updated whenever the total nursing facility service per  
13 diems are updated. Beginning July 1, 2022, upon the  
14 implementation of the Patient Driven Payment Model, Medicaid  
15 rates for supportive living services must be at least 54.3% of  
16 the average total nursing services per diem rate for the  
17 geographic areas. For purposes of this provision, the average  
18 total nursing services per diem rate shall include all add-ons  
19 for nursing facilities for the geographic area provided for in  
20 Section 5-5.2. The rate differential for dementia care must be  
21 maintained in these rates and the rates shall be updated  
22 whenever nursing facility per diem rates are updated.

23 Subject to federal approval, beginning January 1, 2024,  
24 the dementia care rate for supportive living services must be  
25 no less than the non-dementia care supportive living services  
26 rate multiplied by 1.5.

1       (b-5) Subject to federal approval, beginning January 1,  
2       2025, Medicaid rates for supportive living services must be at  
3       least 54.75% of the average total nursing services per diem  
4       rate for the geographic areas defined by the Department and  
5       shall include all add-ons for nursing facilities for the  
6       geographic area provided for in Section 5-5.2.

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

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

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

24           (2) those distinct parts of the site or building are  
25           completely separate from the part of the building used for  
26           the provision of supportive living program services,



1 including separate entrances;

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

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

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

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

1 improvement activities. The Department may alter the form,  
2 methods, or timeframes concerning the supplemental per diem  
3 rate to comply with any subsequent changes to federal law,  
4 changes made by guidance issued by the federal Centers for  
5 Medicare and Medicaid Services, or other changes necessary to  
6 receive the enhanced federal medical assistance percentage.

7 (g) All applications for the expansion of supportive  
8 living dementia care settings involving sites not approved by  
9 the Department on January 1, 2024 (the effective date of  
10 Public Act 103-102) ~~this amendatory Act of the 103rd General~~  
11 ~~Assembly~~ may allow new elderly non-dementia units in addition  
12 to new dementia care units. The Department may approve such  
13 applications only if the application has: (1) no more than one  
14 non-dementia care unit for each dementia care unit and (2) the  
15 site is not located within 4 miles of an existing supportive  
16 living program site in Cook County (including the City of  
17 Chicago), not located within 12 miles of an existing  
18 supportive living program site in DuPage County, Kane County,  
19 Lake County, McHenry County, or Will County, or not located  
20 within 25 miles of an existing supportive living program site  
21 in any other county.

22 (h) Beginning January 1, 2025, subject to federal  
23 approval, for a person who is a resident of a supportive living  
24 facility under this Section, the monthly personal needs  
25 allowance shall be \$120 per month.

26 (Source: P.A. 102-43, eff. 7-6-21; 102-699, eff. 4-19-22;

1 103-102, Article 20, Section 20-5, eff. 1-1-24; 103-102,  
2 Article 100, Section 100-5, eff. 1-1-24; revised 12-15-23.)

3 ARTICLE 20.

4 Section 20-5. The Birth Center Licensing Act is amended by  
5 changing Section 40 as follows:

6 (210 ILCS 170/40)

7 Sec. 40. Reimbursement requirements.

8 (a) A birth center shall seek certification under Titles  
9 XVIII and XIX of the federal Social Security Act.

10 (b) Services provided to individuals eligible for medical  
11 assistance shall be covered in accordance with Article V of  
12 the Illinois Public Aid Code and reimbursement rates shall be  
13 set by the Department of Healthcare and Family Services.  
14 ~~Reimbursement rates set by the Department of Healthcare and~~  
15 ~~Family Services should be based on all types of medically~~  
16 ~~necessary covered services provided to both the birthing~~  
17 ~~person and the baby, including:~~

18 ~~(1) a professional fee for both the birthing person~~  
19 ~~and baby;~~

20 ~~(2) a facility fee for the birthing person that is no~~  
21 ~~less than 75% of the statewide average facility payment~~  
22 ~~rate made to a hospital for an uncomplicated vaginal~~  
23 ~~birth;~~

1           ~~(3) a facility fee for the baby that is no less than~~  
2           ~~75% of the statewide average facility payment rate made to~~  
3           ~~a hospital for a normal baby; and~~

4           ~~(4) additional fees for other services, medications,~~  
5           ~~laboratory tests, and supplies provided.~~

6           (c) A birth center shall provide charitable care  
7           consistent with that provided by comparable health care  
8           providers in the geographic area.

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

12          (Source: P.A. 102-518, eff. 8-20-21.)

13          Section 20-10. The Illinois Public Aid Code is amended by  
14          adding Section 5-18.3 as follows:

15               (305 ILCS 5/5-18.3 new)

16               Sec. 5-18.3. Birth center; facility fee.

17               (a) Reimbursement for services covered under this Article  
18               and provided at a birth center as defined in Section 5 of the  
19               Birth Center Licensing Act shall include:

20                       (1) Beginning January 1, 2025, subject to federal  
21                       approval, a facility fee for the birthing person and baby  
22                       that is no less than 80% of the statewide average facility  
23                       payment rate made to a hospital for an uncomplicated  
24                       vaginal birth. The facility fee shall include medications,

1 laboratory tests, and supplies provided.

2 (2) Beginning January 1, 2025, no less than 80% of the  
3 Department fee schedule rate for professional services for  
4 the birthing person and baby covered under this Article  
5 that are reimbursable separate from the facility fee and  
6 provided within the scope of licensure or certification of  
7 both the practitioner and birth center.

8 (b) The Department shall submit any necessary application  
9 to the federal Centers for Medicare and Medicaid Services for  
10 a waiver or State Plan amendment to implement the requirements  
11 of this Section.

12 ARTICLE 30.

13 Section 30-5. The Illinois Public Aid Code is amended by  
14 changing Sections 5H-1 and 5H-3 as follows:

15 (305 ILCS 5/5H-1)

16 Sec. 5H-1. Definitions. As used in this Article:

17 "Base year" means the 12-month period from January 1, 2023  
18 ~~2018~~ to December 31, 2023 ~~2018~~.

19 "Department" means the Department of Healthcare and Family  
20 Services.

21 "Federal employee health benefit" means the program of  
22 health benefits plans, as defined in 5 U.S.C. 8901, available  
23 to federal employees under 5 U.S.C. 8901 to 8914.

1 "Fund" means the Healthcare Provider Relief Fund.

2 "Managed care organization" means an entity operating  
3 under a certificate of authority issued pursuant to the Health  
4 Maintenance Organization Act or as a Managed Care Community  
5 Network pursuant to Section 5-11 of this Code.

6 "Medicaid managed care organization" means a managed care  
7 organization under contract with the Department to provide  
8 services to recipients of benefits in the medical assistance  
9 program pursuant to Article V of this Code, the Children's  
10 Health Insurance Program Act, or the Covering ALL KIDS Health  
11 Insurance Act. It does not include contracts the same entity  
12 or an affiliated entity has for other business.

13 "Medicare" means the federal Medicare program established  
14 under Title XVIII of the federal Social Security Act.

15 "Member months" means the aggregate total number of months  
16 all individuals are enrolled for coverage in a Managed Care  
17 Organization during the base year. Member months are  
18 determined by the Department for Medicaid Managed Care  
19 Organizations based on enrollment data in its Medicaid  
20 Management Information System and by the Department of  
21 Insurance for other Managed Care Organizations based on  
22 required filings with the Department of Insurance. Member  
23 months do not include months individuals are enrolled in a  
24 Limited Health Services Organization, including stand-alone  
25 dental or vision plans, a Medicare Advantage Plan, a Medicare  
26 Supplement Plan, a Medicaid Medicare Alignment Initiate Plan

1 pursuant to a Memorandum of Understanding between the  
2 Department and the Federal Centers for Medicare and Medicaid  
3 Services or a Federal Employee Health Benefits Plan.

4 (Source: P.A. 101-9, eff. 6-5-19; 102-558, eff. 8-20-21.)

5 (305 ILCS 5/5H-3)

6 Sec. 5H-3. Managed care assessment.

7 (a) ~~There is For State Fiscal year 2020 through State~~  
8 ~~Fiscal Year 2025, there is~~ imposed upon managed care  
9 organization member months an assessment, calculated on base  
10 year data, as set forth below for the appropriate tier:

11 (1) Tier 1: \$78.90 ~~\$60.20~~ per member month.

12 (2) Tier 2: \$1.40 ~~\$1.20~~ per member month.

13 (3) Tier 3: \$2.40 per member month.

14 (b) The tiers are established as follows:

15 (1) Tier 1 includes the first 4,195,000 member months  
16 in a Medicaid managed care organization for the base year;

17 (2) ~~(ii)~~ Tier 2 includes member months over 4,195,000  
18 in a Medicaid managed care organization during the base  
19 year; and

20 (3) ~~(iv)~~ Tier 3 includes member months during the base  
21 year in a managed care organization that is not a Medicaid  
22 managed care organization.

23 (c) For State fiscal year 2020, and for each State fiscal  
24 year thereafter, ~~through State fiscal year 2025,~~ the  
25 Department may ~~by rule~~ adjust rates or tier parameters or both

1 in order to maximize the revenue generated by the assessment  
2 consistent with federal regulations and to meet federal  
3 statistical tests necessary for federal financial  
4 participation. Any upward adjustment to the Tier 3 rate shall  
5 be the minimum necessary to meet federal statistical tests.

6 (Source: P.A. 101-9, eff. 6-5-19.)

7 ARTICLE 35.

8 Section 35-5. The Illinois Administrative Procedure Act is  
9 amended by adding Section 5-45.55 as follows:

10 (5 ILCS 100/5-45.55 new)

11 Sec. 5-45.55. Emergency rulemaking; Medicaid hospital rate  
12 updates. To provide for the expeditious and timely  
13 implementation of the changes made to Section 14-12.5 of the  
14 Illinois Public Aid Code by this amendatory Act of the 103rd  
15 General Assembly, emergency rules implementing the changes  
16 made by this amendatory Act of the 103rd General Assembly to  
17 Section 14-12.5 of the Illinois Public Aid Code may be adopted  
18 in accordance with Section 5-45 by the Department of  
19 Healthcare and Family Services. The adoption of emergency  
20 rules authorized by Section 5-45 and this Section is deemed to  
21 be necessary for the public interest, safety, and welfare.

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



1           Section 35-10. The Illinois Public Aid Code is amended by  
2 changing Section 14-12.5 as follows:

3           (305 ILCS 5/14-12.5)

4           Sec. 14-12.5. Hospital rate updates.

5           (a) Notwithstanding any other provision of this Code, the  
6 hospital rates of reimbursement authorized under Sections  
7 5-5.05, 14-12, and 14-13 of this Code shall be adjusted in  
8 accordance with the provisions of this Section.

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

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

17           (2) For inpatient psychiatric services:

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

23           (B) For all general acute care hospitals that are  
24 not safety-net hospitals, the inpatient psychiatric

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

13 (C) For all psychiatric specialty hospitals, the  
14 per diem rates in effect January 1, 2023, shall be  
15 increased by 10%, except that all rates shall be at  
16 least 90% of the minimum inpatient per diem rate for  
17 safety-net hospitals as authorized in subsection (b-5)  
18 of Section 5-5.05 of this Code, including the  
19 adjustments authorized in this Section. The statewide  
20 default per diem rate for a new psychiatric specialty  
21 hospital shall be set at 90% of the minimum inpatient  
22 psychiatric care per diem rate for safety-net  
23 hospitals as authorized in subsection (b-5) of Section  
24 5-5.05 of this Code, including the adjustment  
25 authorized in this Section.

26 (3) For inpatient rehabilitative services, all

1 hospital specific per diem rates in effect January 1,  
2 2023, shall be increased by 10%. The statewide default  
3 inpatient rehabilitative services per diem rates, for  
4 general acute care hospitals and for rehabilitation  
5 specialty hospitals respectively, shall be increased by  
6 10%.

7 (4) The statewide-standardized amount for outpatient  
8 general acute care services in effect January 1, 2023,  
9 shall be increased by 10%.

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

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

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

19 (8) For services provided ~~Beginning~~ on and after  
20 January 1, 2024 through June 30, 2024, and on and after  
21 January 1, 2027, subject to federal approval, in addition  
22 to the statewide standardized amount, an add-on payment of  
23 at least \$210 shall be paid for each inpatient General  
24 Acute and Psychiatric day of care, excluding  
25 Medicare-Medicaid dual eligible crossover days, for all  
26 safety-net hospitals defined in Section 5-5e.1 of this

1 Code.

2 (A) For Psychiatric days of care, the Department  
3 may implement payment of this add-on by increasing the  
4 hospital specific psychiatric per diem rate, adjusted  
5 in accordance with subparagraph (A) of paragraph (2)  
6 of subsection (b) by \$210, or by a separate add-on  
7 payment.

8 (B) If the add-on adjustment is added to the  
9 hospital specific psychiatric per diem rate to  
10 operationalize payment, the Department shall provide a  
11 rate sheet to each safety-net hospital, which  
12 identifies the hospital psychiatric per diem rate  
13 before and after the adjustment.

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

17 (9) For services provided on and after July 1, 2024,  
18 and on or before December 31, 2026, subject to federal  
19 approval, in addition to the statewide standardized amount  
20 and any other payments authorized under this Code, a  
21 safety-net hospital health care equity add-on payment  
22 shall be paid for each inpatient General Acute and  
23 Psychiatric day of care, excluding Medicare-Medicaid dual  
24 eligible crossover days, for safety-net hospitals defined  
25 in Section 5-5e.1 of this Code, as follows:

26 (A) if the safety-net hospital's Medicaid

1 inpatient utilization rate, as calculated under  
2 Section 5-5e.1 of this Code, is equal to or greater  
3 than 70%, the add-on payment shall be \$425;

4 (B) if the safety-net hospital's Medicaid  
5 inpatient utilization rate, as calculated under  
6 Section 5-5e.1 of this Code, is equal to or greater  
7 than 50% and less than 70%, the add-on payment shall be  
8 \$300;

9 (C) if the safety-net hospital's Medicaid  
10 inpatient utilization rate, as calculated under  
11 Section 5-5e.1 of this Code, is equal to or greater  
12 than 40% and less than 50%, the add-on payment shall be  
13 \$225; and

14 (D) if the safety-net hospital's Medicaid  
15 inpatient utilization rate, as calculated under  
16 Section 5-5e.1 of this Code, is less than 40%, the  
17 add-on payment shall be \$210.

18 Qualification for the safety-net hospital health care  
19 equity add-on payment shall be updated January 1, 2026,  
20 based on the MIUR determination effective 3 months prior  
21 to the start of the January 1, 2026 calendar year.

22 Rates described in subparagraphs (A) through (C) shall  
23 be adjusted annually beginning January 1, 2026 by applying  
24 a uniform factor to each rate to spend an approximate  
25 amount of \$50,000,000 annually per year using State fiscal  
26 year 2024 days as a basis for calendar year 2026 rates.

1           The add-on adjustment under this paragraph shall not  
2           be considered when setting the 90% minimum rate identified  
3           in subparagraph (B) of paragraph (2).

4           (10) For services provided on and after July 1, 2024,  
5           and on or before December 31, 2026, subject to federal  
6           approval, in addition to the statewide standardized amount  
7           and any other payments authorized under this Code, a  
8           safety-net hospital low volume add-on payment of \$200  
9           shall be paid for each inpatient General Acute and  
10           Psychiatric day of care, excluding Medicare-Medicaid dual  
11           eligible crossover days, for any safety-net hospital as  
12           defined in Section 5-5e.1 that provided less than 11,000  
13           Medicaid inpatient days of care, excluding  
14           Medicare-Medicaid dual eligible crossover days, in the  
15           base period. As used in this paragraph, "base period"  
16           means State fiscal year 2022 admissions received by the  
17           Department prior to October 1, 2023 for the payment period  
18           July 1, 2024 through December 31, 2025, and beginning in  
19           calendar year 2026, the State fiscal year that ends 30  
20           months before the applicable calendar year, such as State  
21           fiscal year 2023 admissions received by the Department  
22           prior to October 1, 2024, for calendar year 2026.

23           (c) The Department shall take all actions necessary to  
24           ensure the changes authorized in Public Act 103-102 and this  
25           amendatory Act of the 103rd General Assembly are in effect for  
26           dates of service on and after the effective date of the changes

1 made to this Section by this amendatory Act of the 103rd  
2 General Assembly, ~~January 1, 2024,~~ including publishing all  
3 appropriate public notices, applying for federal approval of  
4 amendments to the Illinois Title XIX State Plan, and adopting  
5 administrative rules if necessary.

6 (d) The Department of Healthcare and Family Services may  
7 adopt rules necessary to implement the changes made by Public  
8 Act 103-102 and this amendatory Act of the 103rd General  
9 Assembly through the use of emergency rulemaking in accordance  
10 with Section 5-45 of the Illinois Administrative Procedure  
11 Act. The 24-month limitation on the adoption of emergency  
12 rules does not apply to rules adopted under this Section. The  
13 General Assembly finds that the adoption of rules to implement  
14 the changes made by Public Act 103-102 and this amendatory Act  
15 of the 103rd General Assembly is deemed an emergency and  
16 necessary for the public interest, safety, and welfare.

17 (e) The Department shall ensure that all necessary  
18 adjustments to the managed care organization capitation base  
19 rates necessitated by the adjustments in this Section are  
20 completed, published, and applied in accordance with Section  
21 5-30.8 of this Code 90 days prior to the implementation date of  
22 the changes required under Public Act 103-102 and this  
23 amendatory Act of the 103rd General Assembly.

24 (f) The Department shall publish updated rate sheets or  
25 add-on payment amounts, as applicable, for all hospitals 30  
26 days prior to the effective date of the rate increase, or

1 within 30 days after federal approval by the Centers for  
2 Medicare and Medicaid Services, whichever is later.

3 (Source: P.A. 103-102, eff. 6-16-23.)

4 ARTICLE 40.

5 Section 40-5. The Illinois Public Aid Code is amended by  
6 changing Section 5A-12.7 as follows:

7 (305 ILCS 5/5A-12.7)

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

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

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



1 hospital ceases to qualify for payments from the pool, the  
2 payments for all hospitals continuing to qualify for payments  
3 from such pool shall be uniformly adjusted to fully expend the  
4 aggregate net amount of the pool, with such adjustment being  
5 effective on the first day of the second month following the  
6 date the hospital ceases to receive payments from such pool.

7 (b) Amounts moved into claims-based rates and distributed  
8 in accordance with Section 14-12 shall remain in those  
9 claims-based rates.

10 (c) Graduate medical education.

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

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

1           (3) An annualized Medicaid indirect medical education  
2           (IME) payment is calculated for each hospital using its  
3           IME payments (Worksheet E Part A, Line 29, Column 1)  
4           multiplied by the percentage that its Medicaid days  
5           (Worksheet S3 Part I, Column 7, Lines 2, 3, 4, 14, 16-18,  
6           and 32) comprise of its Medicare days (Worksheet S3 Part  
7           I, Column 6, Lines 2, 3, 4, 14, and 16-18).

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

25                 (A) For the period of July 1, 2020 through  
26                 December 31, 2022, the applicable reimbursement factor

1 shall be 22.6%.

2 (B) For the period of January 1, 2023 through  
3 December 31, 2026, the applicable reimbursement factor  
4 shall be 35% for all qualified safety-net hospitals,  
5 as defined in Section 5-5e.1 of this Code, and all  
6 hospitals with 100 or more Full Time Equivalent  
7 Residents and Interns, as reported on the hospital's  
8 Medicare cost report ending in Calendar Year 2018, and  
9 for all other qualified hospitals the applicable  
10 reimbursement factor shall be 30%.

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

22 (1) For critical access hospitals, \$385 per covered  
23 inpatient day contained in paid fee-for-service claims and  
24 \$530 per paid fee-for-service outpatient claim for dates  
25 of service in Calendar Year 2019 in the Department's  
26 Enterprise Data Warehouse as of May 11, 2020.

1           (2) For safety-net hospitals, \$960 per covered  
2 inpatient day contained in paid fee-for-service claims and  
3 \$625 per paid fee-for-service outpatient claim for dates  
4 of service in Calendar Year 2019 in the Department's  
5 Enterprise Data Warehouse as of May 11, 2020.

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

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

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

20           (6) For all general acute care hospitals and high  
21 Medicaid hospitals as defined in subsection (f), \$350 per  
22 covered inpatient day for dates of service in Calendar  
23 Year 2019 contained in paid fee-for-service claims and  
24 \$620 per paid fee-for-service outpatient claim in the  
25 Department's Enterprise Data Warehouse as of May 11, 2020.

26           (7) Alzheimer's treatment access payment. Each

1 Illinois academic medical center or teaching hospital, as  
2 defined in Section 5-5e.2 of this Code, that is identified  
3 as the primary hospital affiliate of one of the Regional  
4 Alzheimer's Disease Assistance Centers, as designated by  
5 the Alzheimer's Disease Assistance Act and identified in  
6 the Department of Public Health's Alzheimer's Disease  
7 State Plan dated December 2016, shall be paid an  
8 Alzheimer's treatment access payment equal to the product  
9 of the qualifying hospital's State Fiscal Year 2018 total  
10 inpatient fee-for-service days multiplied by the  
11 applicable Alzheimer's treatment rate of \$226.30 for  
12 hospitals located in Cook County and \$116.21 for hospitals  
13 located outside Cook County.

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

1 hospital class, under such adjusted rates, remains  
2 substantially similar to the total estimated spending under  
3 the original rates set forth in this subsection.

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

10 (2) For safety-net hospitals, as described in  
11 subsection (f), \$1,350 per inpatient day contained in paid  
12 fee-for-service claims and \$1,350 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 (3) For long term acute care hospitals, \$550 per  
17 covered inpatient day contained in paid fee-for-service  
18 claims for dates of service in Calendar Year 2019 in the  
19 Department's Enterprise Data Warehouse as of August 6,  
20 2021.

21 (4) For freestanding psychiatric hospitals, \$200 per  
22 covered inpatient day contained in paid fee-for-service  
23 claims and \$200 per paid fee-for-service outpatient claim  
24 for dates of service in Calendar Year 2019 in the  
25 Department's Enterprise Data Warehouse as of August 6,  
26 2021.

1           (5) For freestanding rehabilitation hospitals, \$550  
2 per covered inpatient day contained in paid  
3 fee-for-service claims and \$125 per paid fee-for-service  
4 outpatient claim for dates of service in Calendar Year  
5 2019 in the Department's Enterprise Data Warehouse as of  
6 August 6, 2021.

7           (6) For all general acute care hospitals and high  
8 Medicaid hospitals as defined in subsection (f), \$500 per  
9 covered inpatient day for dates of service in Calendar  
10 Year 2019 contained in paid fee-for-service claims and  
11 \$500 per paid fee-for-service outpatient claim in the  
12 Department's Enterprise Data Warehouse as of August 6,  
13 2021.

14           (7) For public hospitals, as defined in subsection  
15 (f), \$275 per covered inpatient day contained in paid  
16 fee-for-service claims and \$275 per paid fee-for-service  
17 outpatient claim for dates of service in Calendar Year  
18 2019 in the Department's Enterprise Data Warehouse as of  
19 August 6, 2021.

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

1 State Plan dated December 2016, shall be paid an  
2 Alzheimer's treatment access payment equal to the product  
3 of the qualifying hospital's Calendar Year 2019 total  
4 inpatient fee-for-service days, in the Department's  
5 Enterprise Data Warehouse as of August 6, 2021, multiplied  
6 by the applicable Alzheimer's treatment rate of \$244.37  
7 for hospitals located in Cook County and \$312.03 for  
8 hospitals located outside Cook County.

9 (e) The Department shall require managed care  
10 organizations (MCOs) to make directed payments and  
11 pass-through payments according to this Section. Each calendar  
12 year, the Department shall require MCOs to pay the maximum  
13 amount out of these funds as allowed as pass-through payments  
14 under federal regulations. The Department shall require MCOs  
15 to make such pass-through payments as specified in this  
16 Section. The Department shall require the MCOs to pay the  
17 remaining amounts as directed Payments as specified in this  
18 Section. The Department shall issue payments to the  
19 Comptroller by the seventh business day of each month for all  
20 MCOs that are sufficient for MCOs to make the directed  
21 payments and pass-through payments according to this Section.  
22 The Department shall require the MCOs to make pass-through  
23 payments and directed payments using electronic funds  
24 transfers (EFT), if the hospital provides the information  
25 necessary to process such EFTs, in accordance with directions  
26 provided monthly by the Department, within 7 business days of



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

1 issued.

2 (f)(1) For purposes of allocating the funds included in  
3 capitation payments to MCOs, Illinois hospitals shall be  
4 divided into the following classes as defined in  
5 administrative rules:

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

12 (B) Safety-net hospitals, except that stand-alone  
13 children's hospitals that are not specialty children's  
14 hospitals and, for calendar years 2025 and 2026 only,  
15 hospitals with over 9,000 Medicaid acute care inpatient  
16 admissions per calendar year, excluding admissions for  
17 Medicare-Medicaid dual eligible patients, will not be  
18 included. For the calendar year beginning January 1, 2023,  
19 and each calendar year thereafter, assignment to the  
20 safety-net class shall be based on the annual safety-net  
21 rate year beginning 15 months before the beginning of the  
22 first Payout Quarter of the calendar year.

23 (C) Long term acute care hospitals.

24 (D) Freestanding psychiatric hospitals.

25 (E) Freestanding rehabilitation hospitals.

26 (F) Beginning January 1, 2023, "public hospital" means

1 a hospital that is owned or operated by an Illinois  
2 Government body or municipality, excluding a hospital  
3 provider that is a State agency, a State university, or a  
4 county with a population of 3,000,000 or more.

5 (G) High Medicaid hospitals.

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

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

1 hospital.

2 (II) For the calendar year beginning January  
3 1, 2023, and each calendar year thereafter, is not  
4 a public hospital, safety-net hospital, or  
5 critical access hospital and that qualifies as a  
6 regional high volume hospital or is a hospital  
7 that has a Medicaid Inpatient Utilization Rate  
8 (MIUR) above 30%. As used in this item, "regional  
9 high volume hospital" means a hospital which ranks  
10 in the top 2 quartiles based on total hospital  
11 services volume, of all eligible general acute  
12 care hospitals, when ranked in descending order  
13 based on total hospital services volume, within  
14 the same Medicaid managed care region, as  
15 designated by the Department, as of January 1,  
16 2022. As used in this item, "total hospital  
17 services volume" means the total of all Medical  
18 Assistance hospital inpatient admissions plus all  
19 Medical Assistance hospital outpatient visits. For  
20 purposes of determining regional high volume  
21 hospital inpatient admissions and outpatient  
22 visits, the Department shall use dates of service  
23 provided during State Fiscal Year 2020 for the  
24 Payout Quarter beginning January 1, 2023. The  
25 Department shall use dates of service from the  
26 State fiscal year ending 18 month before the

1 beginning of the first Payout Quarter of the  
2 subsequent annual determination period.

3 (ii) For the calendar year beginning January 1,  
4 2023, the Department shall use the Rate Year 2022  
5 Medicaid inpatient utilization rate (MIUR), as defined  
6 in subsection (h) of Section 5-5.02. For each  
7 subsequent annual determination, the Department shall  
8 use the MIUR applicable to the rate year ending  
9 September 30 of the year preceding the beginning of  
10 the calendar year.

11 (H) General acute care hospitals. As used under this  
12 Section, "general acute care hospitals" means all other  
13 Illinois hospitals not identified in subparagraphs (A)  
14 through (G).

15 (2) Hospitals' qualification for each class shall be  
16 assessed prior to the beginning of each calendar year and the  
17 new class designation shall be effective January 1 of the next  
18 year. The Department shall publish by rule the process for  
19 establishing class determination.

20 (3) Beginning January 1, 2024, the Department may reassign  
21 hospitals or entire hospital classes as defined above, if  
22 federal limits on the payments to the class to which the  
23 hospitals are assigned based on the criteria in this  
24 subsection prevent the Department from making payments to the  
25 class that would otherwise be due under this Section. The  
26 Department shall publish the criteria and composition of each

1 new class based on the reassignments, and the projected impact  
2 on payments to each hospital under the new classes on its  
3 website by November 15 of the year before the year in which the  
4 class changes become effective.

5 (g) Fixed pool directed payments. Beginning July 1, 2020,  
6 the Department shall issue payments to MCOs which shall be  
7 used to issue directed payments to qualified Illinois  
8 safety-net hospitals and critical access hospitals on a  
9 monthly basis in accordance with this subsection. Prior to the  
10 beginning of each Payout Quarter beginning July 1, 2020, the  
11 Department shall use encounter claims data from the  
12 Determination Quarter, accepted by the Department's Medicaid  
13 Management Information System for inpatient and outpatient  
14 services rendered by safety-net hospitals and critical access  
15 hospitals to determine a quarterly uniform per unit add-on for  
16 each hospital class.

17 (1) Inpatient per unit add-on. A quarterly uniform per  
18 diem add-on shall be derived by dividing the quarterly  
19 Inpatient Directed Payments Pool amount allocated to the  
20 applicable hospital class by the total inpatient days  
21 contained on all encounter claims received during the  
22 Determination Quarter, for all hospitals in the class.

23 (A) Each hospital in the class shall have a  
24 quarterly inpatient directed payment calculated that  
25 is equal to the product of the number of inpatient days  
26 attributable to the hospital used in the calculation

1 of the quarterly uniform class per diem add-on,  
2 multiplied by the calculated applicable quarterly  
3 uniform class per diem add-on of the hospital class.

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

8 (2) Outpatient per unit add-on. A quarterly uniform  
9 per claim add-on shall be derived by dividing the  
10 quarterly Outpatient Directed Payments Pool amount  
11 allocated to the applicable hospital class by the total  
12 outpatient encounter claims received during the  
13 Determination Quarter, for all hospitals in the class.

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

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

26 (3) Each MCO shall pay each hospital the Monthly

1 Directed Payment as identified by the Department on its  
2 quarterly determination report.

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

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

6 (B) "Determination Quarter" means each 3 month  
7 calendar quarter, which ends 3 months prior to the  
8 first day of each Payout Quarter.

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

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

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

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

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

21 (6) For the period January 1, 2023 through December  
22 31, 2023, the Department shall establish the amounts that  
23 shall be allocated to the hospital class directed payment  
24 fixed pools identified in this paragraph for the quarterly  
25 development of a uniform per unit add-on. The Department  
26 shall establish such amounts so that the total amount of



1 payments to each hospital under this Section in calendar  
2 year 2023 is projected to be substantially similar to the  
3 total amount of such payments received by the hospital  
4 under this Section in calendar year 2021, adjusted for  
5 increased funding provided for fixed pool directed  
6 payments under subsection (g) in calendar year 2022,  
7 assuming that the volume and acuity of claims are held  
8 constant. The Department shall publish the directed  
9 payment fixed pool amounts to be established under this  
10 paragraph on its website by November 15, 2022.

11 (A) Hospital inpatient services for critical  
12 access hospitals.

13 (B) Hospital outpatient services for critical  
14 access hospitals.

15 (C) Hospital inpatient services for public  
16 hospitals.

17 (D) Hospital outpatient services for public  
18 hospitals.

19 (E) Hospital inpatient services for safety-net  
20 hospitals.

21 (F) Hospital outpatient services for safety-net  
22 hospitals.

23 (7) Semi-annual rate maintenance review. The  
24 Department shall ensure that hospitals assigned to the  
25 fixed pools in paragraph (6) are paid no less than 95% of  
26 the annual initial rate for each 6-month period of each

1 annual payout period. For each calendar year, the  
2 Department shall calculate the annual initial rate per day  
3 and per visit for each fixed pool hospital class listed in  
4 paragraph (6), by dividing the total of all applicable  
5 inpatient or outpatient directed payments issued in the  
6 preceding calendar year to the hospitals in each fixed  
7 pool class for the calendar year, plus any increase  
8 resulting from the annual adjustments described in  
9 subsection (i), by the actual applicable total service  
10 units for the preceding calendar year which were the basis  
11 of the total applicable inpatient or outpatient directed  
12 payments issued to the hospitals in each fixed pool class  
13 in the calendar year, except that for calendar year 2023,  
14 the service units from calendar year 2021 shall be used.

15 (A) The Department shall calculate the effective  
16 rate, per day and per visit, for the payout periods of  
17 January to June and July to December of each year, for  
18 each fixed pool listed in paragraph (6), by dividing  
19 50% of the annual pool by the total applicable  
20 reported service units for the 2 applicable  
21 determination quarters.

22 (B) If the effective rate calculated in  
23 subparagraph (A) is less than 95% of the annual  
24 initial rate assigned to the class for each pool under  
25 paragraph (6), the Department shall adjust the payment  
26 for each hospital to a level equal to no less than 95%

1           of the annual initial rate, by issuing a retroactive  
2           adjustment payment for the 6-month period under review  
3           as identified in subparagraph (A).

4           (h) Fixed rate directed payments. Effective July 1, 2020,  
5           the Department shall issue payments to MCOs which shall be  
6           used to issue directed payments to Illinois hospitals not  
7           identified in paragraph (g) on a monthly basis. Prior to the  
8           beginning of each Payout Quarter beginning July 1, 2020, the  
9           Department shall use encounter claims data from the  
10          Determination Quarter, accepted by the Department's Medicaid  
11          Management Information System for inpatient and outpatient  
12          services rendered by hospitals in each hospital class  
13          identified in paragraph (f) and not identified in paragraph  
14          (g). For the period July 1, 2020 through December 2020, the  
15          Department shall direct MCOs to make payments as follows:

16               (1) For general acute care hospitals an amount equal  
17               to \$1,750 multiplied by the hospital's category of service  
18               20 case mix index for the determination quarter multiplied  
19               by the hospital's total number of inpatient admissions for  
20               category of service 20 for the determination quarter.

21               (2) For general acute care hospitals an amount equal  
22               to \$160 multiplied by the hospital's category of service  
23               21 case mix index for the determination quarter multiplied  
24               by the hospital's total number of inpatient admissions for  
25               category of service 21 for the determination quarter.

26               (3) For general acute care hospitals an amount equal

1 to \$80 multiplied by the hospital's category of service 22  
2 case mix index for the determination quarter multiplied by  
3 the hospital's total number of inpatient admissions for  
4 category of service 22 for the determination quarter.

5 (4) For general acute care hospitals an amount equal  
6 to \$375 multiplied by the hospital's category of service  
7 24 case mix index for the determination quarter multiplied  
8 by the hospital's total number of category of service 24  
9 paid EAPG (EAPGs) for the determination quarter.

10 (5) For general acute care hospitals an amount equal  
11 to \$240 multiplied by the hospital's category of service  
12 27 and 28 case mix index for the determination quarter  
13 multiplied by the hospital's total number of category of  
14 service 27 and 28 paid EAPGs for the determination  
15 quarter.

16 (6) For general acute care hospitals an amount equal  
17 to \$290 multiplied by the hospital's category of service  
18 29 case mix index for the determination quarter multiplied  
19 by the hospital's total number of category of service 29  
20 paid EAPGs for the determination quarter.

21 (7) For high Medicaid hospitals an amount equal to  
22 \$1,800 multiplied by the hospital's category of service 20  
23 case mix index for the determination quarter multiplied by  
24 the hospital's total number of inpatient admissions for  
25 category of service 20 for the determination quarter.

26 (8) For high Medicaid hospitals an amount equal to

1           \$160 multiplied by the hospital's category of service 21  
2           case mix index for the determination quarter multiplied by  
3           the hospital's total number of inpatient admissions for  
4           category of service 21 for the determination quarter.

5           (9) For high Medicaid hospitals an amount equal to \$80  
6           multiplied by the hospital's category of service 22 case  
7           mix index for the determination quarter multiplied by the  
8           hospital's total number of inpatient admissions for  
9           category of service 22 for the determination quarter.

10          (10) For high Medicaid hospitals an amount equal to  
11          \$400 multiplied by the hospital's category of service 24  
12          case mix index for the determination quarter multiplied by  
13          the hospital's total number of category of service 24 paid  
14          EAPG outpatient claims for the determination quarter.

15          (11) For high Medicaid hospitals an amount equal to  
16          \$240 multiplied by the hospital's category of service 27  
17          and 28 case mix index for the determination quarter  
18          multiplied by the hospital's total number of category of  
19          service 27 and 28 paid EAPGs for the determination  
20          quarter.

21          (12) For high Medicaid hospitals an amount equal to  
22          \$290 multiplied by the hospital's category of service 29  
23          case mix index for the determination quarter multiplied by  
24          the hospital's total number of category of service 29 paid  
25          EAPGs for the determination quarter.

26          (13) For long term acute care hospitals the amount of

1           \$495 multiplied by the hospital's total number of  
2           inpatient days for the determination quarter.

3           (14) For psychiatric hospitals the amount of \$210  
4           multiplied by the hospital's total number of inpatient  
5           days for category of service 21 for the determination  
6           quarter.

7           (15) For psychiatric hospitals the amount of \$250  
8           multiplied by the hospital's total number of outpatient  
9           claims for category of service 27 and 28 for the  
10          determination quarter.

11          (16) For rehabilitation hospitals the amount of \$410  
12          multiplied by the hospital's total number of inpatient  
13          days for category of service 22 for the determination  
14          quarter.

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

19          (18) Effective for the Payout Quarter beginning  
20          January 1, 2023, for the directed payments to hospitals  
21          required under this subsection, the Department shall  
22          establish the amounts that shall be used to calculate such  
23          directed payments using the methodologies specified in  
24          this paragraph. The Department shall use a single, uniform  
25          rate, adjusted for acuity as specified in paragraphs (1)  
26          through (12), for all categories of inpatient services

1 provided by each class of hospitals and a single uniform  
2 rate, adjusted for acuity as specified in paragraphs (1)  
3 through (12), for all categories of outpatient services  
4 provided by each class of hospitals. The Department shall  
5 establish such amounts so that the total amount of  
6 payments to each hospital under this Section in calendar  
7 year 2023 is projected to be substantially similar to the  
8 total amount of such payments received by the hospital  
9 under this Section in calendar year 2021, adjusted for  
10 increased funding provided for fixed pool directed  
11 payments under subsection (g) in calendar year 2022,  
12 assuming that the volume and acuity of claims are held  
13 constant. The Department shall publish the directed  
14 payment amounts to be established under this subsection on  
15 its website by November 15, 2022.

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

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

23 Notwithstanding any other provision of this subsection, if  
24 the Department determines that the actual total hospital  
25 utilization data that is used to calculate the fixed rate  
26 directed payments is substantially different than anticipated

1 when the rates in this subsection were initially determined  
2 for unforeseeable circumstances (such as the COVID-19 pandemic  
3 or some other public health emergency), the Department may  
4 adjust the rates specified in this subsection so that the  
5 total directed payments approximate the total spending amount  
6 anticipated when the rates were initially established.

7 Definitions. As used in this subsection:

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

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

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

26 (i) Beginning January 1, 2021, the rates for directed



1 payments shall be recalculated in order to spend the  
2 additional funds for directed payments that result from  
3 reduction in the amount of pass-through payments allowed under  
4 federal regulations. The additional funds for directed  
5 payments shall be allocated proportionally to each class of  
6 hospitals based on that class' proportion of services.

7 (1) Beginning January 1, 2024, the fixed pool directed  
8 payment amounts and the associated annual initial rates  
9 referenced in paragraph (6) of subsection (f) for each  
10 hospital class shall be uniformly increased by a ratio of  
11 not less than, the ratio of the total pass-through  
12 reduction amount pursuant to paragraph (4) of subsection  
13 (j), for the hospitals comprising the hospital fixed pool  
14 directed payment class for the next calendar year, to the  
15 total inpatient and outpatient directed payments for the  
16 hospitals comprising the hospital fixed pool directed  
17 payment class paid during the preceding calendar year.

18 (2) Beginning January 1, 2024, the fixed rates for the  
19 directed payments referenced in paragraph (18) of  
20 subsection (h) for each hospital class shall be uniformly  
21 increased by a ratio of not less than, the ratio of the  
22 total pass-through reduction amount pursuant to paragraph  
23 (4) of subsection (j), for the hospitals comprising the  
24 hospital directed payment class for the next calendar  
25 year, to the total inpatient and outpatient directed  
26 payments for the hospitals comprising the hospital fixed

1 rate directed payment class paid during the preceding  
2 calendar year.

3 (j) Pass-through payments.

4 (1) For the period July 1, 2020 through December 31,  
5 2020, the Department shall assign quarterly pass-through  
6 payments to each class of hospitals equal to one-fourth of  
7 the following annual allocations:

8 (A) \$390,487,095 to safety-net hospitals.

9 (B) \$62,553,886 to critical access hospitals.

10 (C) \$345,021,438 to high Medicaid hospitals.

11 (D) \$551,429,071 to general acute care hospitals.

12 (E) \$27,283,870 to long term acute care hospitals.

13 (F) \$40,825,444 to freestanding psychiatric  
14 hospitals.

15 (G) \$9,652,108 to freestanding rehabilitation  
16 hospitals.

17 (2) For the period of July 1, 2020 through December  
18 31, 2020, the pass-through payments shall at a minimum  
19 ensure hospitals receive a total amount of monthly  
20 payments under this Section as received in calendar year  
21 2019 in accordance with this Article and paragraph (1) of  
22 subsection (d-5) of Section 14-12, exclusive of amounts  
23 received through payments referenced in subsection (b).

24 (3) For the calendar year beginning January 1, 2023,  
25 the Department shall establish the annual pass-through  
26 allocation to each class of hospitals and the pass-through

1 payments to each hospital so that the total amount of  
2 payments to each hospital under this Section in calendar  
3 year 2023 is projected to be substantially similar to the  
4 total amount of such payments received by the hospital  
5 under this Section in calendar year 2021, adjusted for  
6 increased funding provided for fixed pool directed  
7 payments under subsection (g) in calendar year 2022,  
8 assuming that the volume and acuity of claims are held  
9 constant. The Department shall publish the pass-through  
10 allocation to each class and the pass-through payments to  
11 each hospital to be established under this subsection on  
12 its website by November 15, 2022.

13 (4) For the calendar years beginning January 1, 2021  
14 and January 1, 2022, each hospital's pass-through payment  
15 amount shall be reduced proportionally to the reduction of  
16 all pass-through payments required by federal regulations.  
17 Beginning January 1, 2024, the Department shall reduce  
18 total pass-through payments by the minimum amount  
19 necessary to comply with federal regulations. Pass-through  
20 payments to safety-net hospitals, as defined in Section  
21 5-5e.1 of this Code, shall not be reduced until all  
22 pass-through payments to other hospitals have been  
23 eliminated. All other hospitals shall have their  
24 pass-through payments reduced proportionally.

25 (k) At least 30 days prior to each calendar year, the  
26 Department shall notify each hospital of changes to the

1 payment methodologies in this Section, including, but not  
2 limited to, changes in the fixed rate directed payment rates,  
3 the aggregate pass-through payment amount for all hospitals,  
4 and the hospital's pass-through payment amount for the  
5 upcoming calendar year.

6 (l) Notwithstanding any other provisions of this Section,  
7 the Department may adopt rules to change the methodology for  
8 directed and pass-through payments as set forth in this  
9 Section, but only to the extent necessary to obtain federal  
10 approval of a necessary State Plan amendment or Directed  
11 Payment Preprint or to otherwise conform to federal law or  
12 federal regulation.

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

19 (n) In order to address the escalating infant mortality  
20 rates among minority communities in Illinois, the State shall,  
21 subject to appropriation, create a pool of funding of at least  
22 \$50,000,000 annually to be disbursed among safety-net  
23 hospitals that maintain perinatal designation from the  
24 Department of Public Health. The funding shall be used to  
25 preserve or enhance OB/GYN services or other specialty  
26 services at the receiving hospital, with the distribution of

1 funding to be established by rule and with consideration to  
2 perinatal hospitals with safe birthing levels and quality  
3 metrics for healthy mothers and babies.

4 (o) In order to address the growing challenges of  
5 providing stable access to healthcare in rural Illinois,  
6 including perinatal services, behavioral healthcare including  
7 substance use disorder services (SUDs) and other specialty  
8 services, and to expand access to telehealth services among  
9 rural communities in Illinois, the Department of Healthcare  
10 and Family Services shall administer a program to provide at  
11 least \$10,000,000 in financial support annually to critical  
12 access hospitals for delivery of perinatal and OB/GYN  
13 services, behavioral healthcare including SUDs, other  
14 specialty services and telehealth services. The funding shall  
15 be used to preserve or enhance perinatal and OB/GYN services,  
16 behavioral healthcare including SUDs, other specialty  
17 services, as well as the explanation of telehealth services by  
18 the receiving hospital, with the distribution of funding to be  
19 established by rule.

20 (p) For calendar year 2023, the final amounts, rates, and  
21 payments under subsections (c), (d-2), (g), (h), and (j) shall  
22 be established by the Department, so that the sum of the total  
23 estimated annual payments under subsections (c), (d-2), (g),  
24 (h), and (j) for each hospital class for calendar year 2023, is  
25 no less than:

26 (1) \$858,260,000 to safety-net hospitals.

- 1 (2) \$86,200,000 to critical access hospitals.
- 2 (3) \$1,765,000,000 to high Medicaid hospitals.
- 3 (4) \$673,860,000 to general acute care hospitals.
- 4 (5) \$48,330,000 to long term acute care hospitals.
- 5 (6) \$89,110,000 to freestanding psychiatric hospitals.
- 6 (7) \$24,300,000 to freestanding rehabilitation  
7 hospitals.
- 8 (8) \$32,570,000 to public hospitals.
- 9 (q) Hospital Pandemic Recovery Stabilization Payments. The  
10 Department shall disburse a pool of \$460,000,000 in stability  
11 payments to hospitals prior to April 1, 2023. The allocation  
12 of the pool shall be based on the hospital directed payment  
13 classes and directed payments issued, during Calendar Year  
14 2022 with added consideration to safety net hospitals, as  
15 defined in subdivision (f)(1)(B) of this Section, and critical  
16 access hospitals.
- 17 (Source: P.A. 102-4, eff. 4-27-21; 102-16, eff. 6-17-21;  
18 102-886, eff. 5-17-22; 102-1115, eff. 1-9-23; 103-102, eff.  
19 6-16-23; revised 9-21-23.)

20 ARTICLE 45.

21 Section 45-5. The Illinois Public Aid Code is amended by  
22 adding Section 5-5.08a as follows:

23 (305 ILCS 5/5-5.08a new)

1       Sec. 5-5.08a. Renal dialysis; add-on payments for home  
2 dialysis providers in skilled nursing facilities.

3       (a) Findings. The General Assembly finds the following:

4           (1) Home dialysis services provided on-site at skilled  
5 nursing facilities are beneficial to nursing home  
6 residents by permitting more time for other health and  
7 wellness activities, and nullifying burdensome off-site  
8 travel which carries various health care risks and  
9 increased costs.

10           (2) Home dialysis for nursing home residents provides  
11 an on-site venue for high-acuity residents to receive  
12 dialysis services, effectively creating downstream care  
13 opportunities for hospital patients in need of post-acute  
14 care and dialysis, and reducing the total cost of dialysis  
15 care.

16           (3) On-site home dialysis in nursing homes is costlier  
17 for the provider than conventional outpatient dialysis, as  
18 labor costs are greater per treatment and such patients  
19 typically have higher acuities, necessitating more  
20 medication and greater staff involvement to promote  
21 patient compliance.

22       (b) Subject to federal approval, for dates of service  
23 beginning on and after January 1, 2025, for home renal  
24 dialysis provided to residents of skilled nursing facilities,  
25 the Department shall reimburse a per-claim add-on payment to  
26 certified home dialysis providers in accordance with this

1 Section. Certified home dialysis providers providing dialysis  
2 services within a skilled nursing facility shall receive a  
3 per-claim add-on payment of \$95 per treatment. As used in this  
4 Section, "certified home dialysis provider" means an end-stage  
5 renal disease facility that (i) provides dialysis treatment or  
6 dialysis training to caregivers or individuals with end-stage  
7 renal disease and (ii) has been approved to provide dialysis  
8 home training support services by the federal Centers for  
9 Medicare and Medicaid Services.

10 ARTICLE 50.

11 Section 50-5. The Illinois Public Aid Code is amended by  
12 changing Sections 5-5.07 and 14-13 as follows:

13 (305 ILCS 5/5-5.07)

14 Sec. 5-5.07. Inpatient psychiatric stay; DCFS per diem  
15 rate. The Department of Children and Family Services shall pay  
16 the DCFS per diem rate for inpatient psychiatric stay at a  
17 free-standing psychiatric hospital or a hospital with a  
18 pediatric or adolescent inpatient psychiatric unit effective  
19 the 3rd day ~~11th day~~ when a child is in the hospital beyond  
20 medical necessity, and the parent or caregiver has denied the  
21 child access to the home and has refused or failed to make  
22 provisions for another living arrangement for the child or the  
23 child's discharge is being delayed due to a pending inquiry or



1 investigation by the Department of Children and Family  
2 Services. If any portion of a hospital stay is reimbursed  
3 under this Section, the hospital stay shall not be eligible  
4 for payment under the provisions of Section 14-13 of this  
5 Code.

6 (Source: Reenacted by P.A. 101-15, eff. 6-14-19; reenacted by  
7 P.A. 101-209, eff. 8-5-19; P.A. 101-655, eff. 3-12-21;  
8 102-201, eff. 7-30-21; 102-558, eff. 8-20-21; 102-1037, eff.  
9 6-2-22.)

10 (305 ILCS 5/14-13)

11 Sec. 14-13. Reimbursement for inpatient stays extended  
12 beyond medical necessity.

13 (a) By October 1, 2019, the Department shall by rule  
14 implement a methodology effective for dates of service July 1,  
15 2019 and later to reimburse hospitals for inpatient stays  
16 extended beyond medical necessity due to the inability of the  
17 Department or the managed care organization in which a  
18 recipient is enrolled or the hospital discharge planner to  
19 find an appropriate placement after discharge from the  
20 hospital. The Department shall evaluate the effectiveness of  
21 the current reimbursement rate for inpatient hospital stays  
22 beyond medical necessity.

23 (b) The methodology shall provide reasonable compensation  
24 for the services provided attributable to the days of the  
25 extended stay for which the prevailing rate methodology

1 provides no reimbursement. The Department may use a day  
2 outlier program to satisfy this requirement. The reimbursement  
3 rate shall be set at a level so as not to act as an incentive  
4 to avoid transfer to the appropriate level of care needed or  
5 placement, after discharge.

6 (c) The Department shall require managed care  
7 organizations to adopt this methodology or an alternative  
8 methodology that pays at least as much as the Department's  
9 adopted methodology unless otherwise mutually agreed upon  
10 contractual language is developed by the provider and the  
11 managed care organization for a risk-based or innovative  
12 payment methodology.

13 (d) Days beyond medical necessity shall not be eligible  
14 for per diem add-on payments under the Medicaid High Volume  
15 Adjustment (MHVA) or the Medicaid Percentage Adjustment (MPA)  
16 programs.

17 (e) For services covered by the fee-for-service program,  
18 reimbursement under this Section shall only be made for days  
19 beyond medical necessity that occur after the hospital has  
20 notified the Department of the need for post-discharge  
21 placement. For services covered by a managed care  
22 organization, hospitals shall notify the appropriate managed  
23 care organization of an admission within 24 hours of  
24 admission. For every 24-hour period beyond the initial 24  
25 hours after admission that the hospital fails to notify the  
26 managed care organization of the admission, reimbursement

1 under this subsection shall be reduced by one day.

2 (f) The Department of Children and Family Services shall  
3 pay for all inpatient stays beginning on the 3rd day a child is  
4 in the hospital beyond medical necessity, and the parent or  
5 caregiver has denied the child access to the home and has  
6 refused or failed to make provisions for another living  
7 arrangement for the child or the child's discharge is being  
8 delayed due to a pending inquiry or investigation by the  
9 Department of Children and Family Services.

10 (Source: P.A. 101-209, eff. 8-5-19; 102-4, eff. 4-27-21.)

11 ARTICLE 55.

12 Section 55-5. The Illinois Public Aid Code is amended by  
13 adding Section 5-55 as follows:

14 (305 ILCS 5/5-55 new)

15 Sec. 5-55. Reimbursement for music therapy services.  
16 Subject to federal approval, for dates of service beginning on  
17 and after July 1, 2025, the Department shall reimburse music  
18 therapy services provided by licensed professional music  
19 therapists. To be eligible for reimbursement under this  
20 Section, music therapy services must be provided by a licensed  
21 professional music therapist authorized to practice under the  
22 Music Therapy Licensing and Practice Act.

## 1 ARTICLE 60.

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

4 (305 ILCS 5/5-60 new)

5 Sec. 5-60. Optometric services; reimbursement rates.  
6 Notwithstanding any other law or rule to the contrary and  
7 subject to federal approval, for dates of service beginning on  
8 and after January 1, 2025, the reimbursement rates for  
9 optometric and optical services for determining refractive  
10 state, fitting of spectacles, and fitting of bifocal  
11 spectacles shall be increased by 35% above the rates in effect  
12 on January 1, 2024.

## 13 ARTICLE 65.

14 Section 65-5. The Illinois Public Aid Code is amended by  
15 changing Section 5-2.06 as follows:

16 (305 ILCS 5/5-2.06)

17 Sec. 5-2.06. Payment rates; Children's Community-Based  
18 Health Care Centers. Beginning January 1, 2025 and subject to  
19 federal approval ~~2020~~, the Department shall, for eligible  
20 individuals, reimburse Children's Community-Based Health Care  
21 Centers established in the Alternative Health Care Delivery

1 Act and providing nursing care for the purpose of  
2 transitioning children from a hospital to home placement or  
3 other appropriate setting and reuniting families for a maximum  
4 of up to 120 days on a per diem basis at the lower of the  
5 Children's Community-Based Health Care Center's usual and  
6 customary charge to the public or at the Department rate of  
7 \$1,300 ~~\$950~~. Payments at the rate set forth in this Section are  
8 exempt from the 2.7% rate reduction required under Section  
9 5-5e.

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

11 ARTICLE 70.

12 Section 70-5. The Illinois Public Aid Code is amended by  
13 adding Section 5-5.24a as follows:

14 (305 ILCS 5/5-5.24a new)

15 Sec. 5-5.24a. Remote ultrasounds and remote fetal  
16 nonstress tests; reimbursement.

17 (a) Subject to federal approval, for dates of service  
18 beginning on and after January 1, 2025, the Department shall  
19 reimburse for remote ultrasound procedures and remote fetal  
20 nonstress tests when the patient is in a residence or other  
21 off-site location from the patient's provider and the same  
22 standard of care is met as would be present during an in-person  
23 visit.

1           (b) Remote ultrasounds and remote fetal nonstress tests  
2 are only eligible for reimbursement when the provider uses  
3 digital technology:

4                 (1) to collect medical and other forms of health data  
5 from a patient and to electronically transmit that  
6 information securely to a health care provider in a  
7 different location for interpretation and recommendation;

8                 (2) that is compliant with the federal Health  
9 Insurance Portability and Accountability Act of 1996; and

10                (3) that is approved by the U.S. Food and Drug  
11 Administration.

12           (c) A fetal nonstress test is only eligible for  
13 reimbursement with a place of service modifier for at-home  
14 monitoring with remote monitoring solutions that are cleared  
15 by the U.S. Food and Drug Administration for on-label use for  
16 monitoring fetal heart rate, maternal heart rate, and uterine  
17 activity.

18           (d) The Department shall issue guidance to implement the  
19 provisions of this Section.

20   ARTICLE 75.

21           Section 75-5. The Illinois Public Aid Code is amended by  
22 changing Section 5-2b as follows:

23                           (305 ILCS 5/5-2b)

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

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

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

1 services on December 31, 2023.

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

10 (Source: P.A. 103-102, eff. 1-1-24.)

11 ARTICLE 80.

12 Section 80-5. The Illinois Public Aid Code is amended by  
13 adding Section 5-52 as follows:

14 (305 ILCS 5/5-52 new)

15 Sec. 5-52. Custom prosthetic and orthotic devices;  
16 reimbursement rates. Subject to federal approval, for dates of  
17 service beginning on and after January 1, 2025, the Department  
18 shall increase the current 2024 Medicaid rate by 7% under the  
19 medical assistance program for custom prosthetic and orthotic  
20 devices.

21 ARTICLE 85.



1           Section 85-5. The Illinois Public Aid Code is amended by  
2 changing Section 5-4.2 as follows:

3           (305 ILCS 5/5-4.2)

4           Sec. 5-4.2. Ambulance services payments.

5           (a) For ambulance services provided to a recipient of aid  
6 under this Article on or after January 1, 1993, the Illinois  
7 Department shall reimburse ambulance service providers at  
8 rates calculated in accordance with this Section. It is the  
9 intent of the General Assembly to provide adequate  
10 reimbursement for ambulance services so as to ensure adequate  
11 access to services for recipients of aid under this Article  
12 and to provide appropriate incentives to ambulance service  
13 providers to provide services in an efficient and  
14 cost-effective manner. Thus, it is the intent of the General  
15 Assembly that the Illinois Department implement a  
16 reimbursement system for ambulance services that, to the  
17 extent practicable and subject to the availability of funds  
18 appropriated by the General Assembly for this purpose, is  
19 consistent with the payment principles of Medicare. To ensure  
20 uniformity between the payment principles of Medicare and  
21 Medicaid, the Illinois Department shall follow, to the extent  
22 necessary and practicable and subject to the availability of  
23 funds appropriated by the General Assembly for this purpose,  
24 the statutes, laws, regulations, policies, procedures,  
25 principles, definitions, guidelines, and manuals used to

1 determine the amounts paid to ambulance service providers  
2 under Title XVIII of the Social Security Act (Medicare).

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

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

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

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

1 by the Centers for Medicare and Medicaid Services.

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

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

13 (c-5) For purposes of this Section, "air ambulance  
14 service" means medical transport by helicopter or airplane for  
15 patients, as defined in 29 U.S.C. 1185f(c)(1), and any service  
16 that is described as an air ambulance service by the federal  
17 Centers for Medicare and Medicaid Services.

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

21 (e) Beginning with services rendered on or after July 1,  
22 2008, all providers of non-emergency medi-car and service car  
23 transportation must certify that the driver and employee  
24 attendant, as applicable, have completed a safety program  
25 approved by the Department to protect both the patient and the  
26 driver, prior to transporting a patient. The provider must

1 maintain this certification in its records. The provider shall  
2 produce such documentation upon demand by the Department or  
3 its representative. Failure to produce documentation of such  
4 training shall result in recovery of any payments made by the  
5 Department for services rendered by a non-certified driver or  
6 employee attendant. Medi-car and service car providers must  
7 maintain legible documentation in their records of the driver  
8 and, as applicable, employee attendant that actually  
9 transported the patient. Providers must recertify all drivers  
10 and employee attendants every 3 years. If they meet the  
11 established training components set forth by the Department,  
12 providers of non-emergency medi-car and service car  
13 transportation that are either directly or through an  
14 affiliated company licensed by the Department of Public Health  
15 shall be approved by the Department to have in-house safety  
16 programs for training their own staff.

17 Notwithstanding the requirements above, any public  
18 transportation provider of medi-car and service car  
19 transportation that receives federal funding under 49 U.S.C.  
20 5307 and 5311 need not certify its drivers and employee  
21 attendants under this Section, since safety training is  
22 already federally mandated.

23 (f) With respect to any policy or program administered by  
24 the Department or its agent regarding approval of  
25 non-emergency medical transportation by ground ambulance  
26 service providers, including, but not limited to, the

1 Non-Emergency Transportation Services Prior Approval Program  
2 (NETSPAP), the Department shall establish by rule a process by  
3 which ground ambulance service providers of non-emergency  
4 medical transportation may appeal any decision by the  
5 Department or its agent for which no denial was received prior  
6 to the time of transport that either (i) denies a request for  
7 approval for payment of non-emergency transportation by means  
8 of ground ambulance service or (ii) grants a request for  
9 approval of non-emergency transportation by means of ground  
10 ambulance service at a level of service that entitles the  
11 ground ambulance service provider to a lower level of  
12 compensation from the Department than the ground ambulance  
13 service provider would have received as compensation for the  
14 level of service requested. The rule shall be filed by  
15 December 15, 2012 and shall provide that, for any decision  
16 rendered by the Department or its agent on or after the date  
17 the rule takes effect, the ground ambulance service provider  
18 shall have 60 days from the date the decision is received to  
19 file an appeal. The rule established by the Department shall  
20 be, insofar as is practical, consistent with the Illinois  
21 Administrative Procedure Act. The Director's decision on an  
22 appeal under this Section shall be a final administrative  
23 decision subject to review under the Administrative Review  
24 Law.

25 (f-5) Beginning 90 days after July 20, 2012 (the effective  
26 date of Public Act 97-842), (i) no denial of a request for

1 approval for payment of non-emergency transportation by means  
2 of ground ambulance service, and (ii) no approval of  
3 non-emergency transportation by means of ground ambulance  
4 service at a level of service that entitles the ground  
5 ambulance service provider to a lower level of compensation  
6 from the Department than would have been received at the level  
7 of service submitted by the ground ambulance service provider,  
8 may be issued by the Department or its agent unless the  
9 Department has submitted the criteria for determining the  
10 appropriateness of the transport for first notice publication  
11 in the Illinois Register pursuant to Section 5-40 of the  
12 Illinois Administrative Procedure Act.

13 (f-6) Within 90 days after June 2, 2022 (the effective  
14 date of Public Act 102-1037) ~~this amendatory Act of the 102nd~~  
15 ~~General Assembly~~ and subject to federal approval, the  
16 Department shall file rules to allow for the approval of  
17 ground ambulance services when the sole purpose of the  
18 transport is for the navigation of stairs or the assisting or  
19 lifting of a patient at a medical facility or during a medical  
20 appointment in instances where the Department or a contracted  
21 Medicaid managed care organization or their transportation  
22 broker is unable to secure transportation through any other  
23 transportation provider.

24 (f-7) For non-emergency ground ambulance claims properly  
25 denied under Department policy at the time the claim is filed  
26 due to failure to submit a valid Medical Certification for

1 Non-Emergency Ambulance on and after December 15, 2012 and  
2 prior to January 1, 2021, the Department shall allot  
3 \$2,000,000 to a pool to reimburse such claims if the provider  
4 proves medical necessity for the service by other means.  
5 Providers must submit any such denied claims for which they  
6 seek compensation to the Department no later than December 31,  
7 2021 along with documentation of medical necessity. No later  
8 than May 31, 2022, the Department shall determine for which  
9 claims medical necessity was established. Such claims for  
10 which medical necessity was established shall be paid at the  
11 rate in effect at the time of the service, provided the  
12 \$2,000,000 is sufficient to pay at those rates. If the pool is  
13 not sufficient, claims shall be paid at a uniform percentage  
14 of the applicable rate such that the pool of \$2,000,000 is  
15 exhausted. The appeal process described in subsection (f)  
16 shall not be applicable to the Department's determinations  
17 made in accordance with this subsection.

18 (g) Whenever a patient covered by a medical assistance  
19 program under this Code or by another medical program  
20 administered by the Department, including a patient covered  
21 under the State's Medicaid managed care program, is being  
22 transported from a facility and requires non-emergency  
23 transportation including ground ambulance, medi-car, or  
24 service car transportation, a Physician Certification  
25 Statement as described in this Section shall be required for  
26 each patient. Facilities shall develop procedures for a

1 licensed medical professional to provide a written and signed  
2 Physician Certification Statement. The Physician Certification  
3 Statement shall specify the level of transportation services  
4 needed and complete a medical certification establishing the  
5 criteria for approval of non-emergency ambulance  
6 transportation, as published by the Department of Healthcare  
7 and Family Services, that is met by the patient. This  
8 certification shall be completed prior to ordering the  
9 transportation service and prior to patient discharge. The  
10 Physician Certification Statement is not required prior to  
11 transport if a delay in transport can be expected to  
12 negatively affect the patient outcome. If the ground ambulance  
13 provider, medi-car provider, or service car provider is unable  
14 to obtain the required Physician Certification Statement  
15 within 10 calendar days following the date of the service, the  
16 ground ambulance provider, medi-car provider, or service car  
17 provider must document its attempt to obtain the requested  
18 certification and may then submit the claim for payment.  
19 Acceptable documentation includes a signed return receipt from  
20 the U.S. Postal Service, facsimile receipt, email receipt, or  
21 other similar service that evidences that the ground ambulance  
22 provider, medi-car provider, or service car provider attempted  
23 to obtain the required Physician Certification Statement.

24 The medical certification specifying the level and type of  
25 non-emergency transportation needed shall be in the form of  
26 the Physician Certification Statement on a standardized form



1 prescribed by the Department of Healthcare and Family  
2 Services. Within 75 days after July 27, 2018 (the effective  
3 date of Public Act 100-646), the Department of Healthcare and  
4 Family Services shall develop a standardized form of the  
5 Physician Certification Statement specifying the level and  
6 type of transportation services needed in consultation with  
7 the Department of Public Health, Medicaid managed care  
8 organizations, a statewide association representing ambulance  
9 providers, a statewide association representing hospitals, 3  
10 statewide associations representing nursing homes, and other  
11 stakeholders. The Physician Certification Statement shall  
12 include, but is not limited to, the criteria necessary to  
13 demonstrate medical necessity for the level of transport  
14 needed as required by (i) the Department of Healthcare and  
15 Family Services and (ii) the federal Centers for Medicare and  
16 Medicaid Services as outlined in the Centers for Medicare and  
17 Medicaid Services' Medicare Benefit Policy Manual, Pub.  
18 100-02, Chap. 10, Sec. 10.2.1, et seq. The use of the Physician  
19 Certification Statement shall satisfy the obligations of  
20 hospitals under Section 6.22 of the Hospital Licensing Act and  
21 nursing homes under Section 2-217 of the Nursing Home Care  
22 Act. Implementation and acceptance of the Physician  
23 Certification Statement shall take place no later than 90 days  
24 after the issuance of the Physician Certification Statement by  
25 the Department of Healthcare and Family Services.

26 Pursuant to subsection (E) of Section 12-4.25 of this

1 Code, the Department is entitled to recover overpayments paid  
2 to a provider or vendor, including, but not limited to, from  
3 the discharging physician, the discharging facility, and the  
4 ground ambulance service provider, in instances where a  
5 non-emergency ground ambulance service is rendered as the  
6 result of improper or false certification.

7 Beginning October 1, 2018, the Department of Healthcare  
8 and Family Services shall collect data from Medicaid managed  
9 care organizations and transportation brokers, including the  
10 Department's NETSPAP broker, regarding denials and appeals  
11 related to the missing or incomplete Physician Certification  
12 Statement forms and overall compliance with this subsection.  
13 The Department of Healthcare and Family Services shall publish  
14 quarterly results on its website within 15 days following the  
15 end of each quarter.

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

21 (i) Subject to federal approval, on and after January 1,  
22 2024 ~~through June 30, 2026~~, the Department shall increase the  
23 base rate of reimbursement for both base charges and mileage  
24 charges for ground ambulance service providers not  
25 participating in the Ground Emergency Medical Transportation  
26 (GEMT) Program for medical transportation services provided by

1 means of a ground ambulance to a level not lower than 140% of  
2 the base rate in effect as of January 1, 2023.

3 (j) For the purpose of understanding ground ambulance  
4 transportation services cost structures and their impact on  
5 the Medical Assistance Program, the Department shall engage  
6 stakeholders, including, but not limited to, a statewide  
7 association representing private ground ambulance service  
8 providers in Illinois, to develop recommendations for a plan  
9 for the regular collection of cost data for all ground  
10 ambulance transportation providers reimbursed under the  
11 Illinois Title XIX State Plan. Cost data obtained through this  
12 process shall be used to inform on and to ensure the  
13 effectiveness and efficiency of Illinois Medicaid rates. The  
14 Department shall establish a process to limit public  
15 availability of portions of the cost report data determined to  
16 be proprietary. This process shall be concluded and  
17 recommendations shall be provided no later than December 31,  
18 2025 ~~April 1, 2024~~.

19 (k) ~~(j)~~ Subject to federal approval, beginning on January  
20 1, 2024, the Department shall increase the base rate of  
21 reimbursement for both base charges and mileage charges for  
22 medical transportation services provided by means of an air  
23 ambulance to a level not lower than 50% of the Medicare  
24 ambulance fee schedule rates, by designated Medicare locality,  
25 in effect on January 1, 2023.

26 (Source: P.A. 102-364, eff. 1-1-22; 102-650, eff. 8-27-21;

1 102-813, eff. 5-13-22; 102-1037, eff. 6-2-22; 103-102, Article  
2 70, Section 70-5, eff. 1-1-24; 103-102, Article 80, Section  
3 80-5, eff. 1-1-24; revised 12-15-23.)

4 ARTICLE 90.

5 Section 90-5. The Illinois Public Aid Code is amended by  
6 changing Section 5-5 as follows:

7 (305 ILCS 5/5-5)

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

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

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

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

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

21 Notwithstanding any other provision of this Section, all  
22 tobacco cessation medications approved by the United States  
23 Food and Drug Administration and all individual and group  
24 tobacco cessation counseling services and telephone-based  
25 counseling services and tobacco cessation medications provided  
26 through the Illinois Tobacco Quitline shall be covered under

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

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

25 Upon receipt of federal approval of an amendment to the  
26 Illinois Title XIX State Plan for this purpose, the Department

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

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

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

25 (2) eyeglasses prescribed by a physician skilled in  
26 the diseases of the eye, or by an optometrist, whichever



1 the person may select.

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

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

23 Notwithstanding any other provision of this Code and  
24 subject to federal approval, the Department may adopt rules to  
25 allow a dentist who is volunteering his or her service at no  
26 cost to render dental services through an enrolled

1 not-for-profit health clinic without the dentist personally  
2 enrolling as a participating provider in the medical  
3 assistance program. A not-for-profit health clinic shall  
4 include a public health clinic or Federally Qualified Health  
5 Center or other enrolled provider, as determined by the  
6 Department, through which dental services covered under this  
7 Section are performed. The Department shall establish a  
8 process for payment of claims for reimbursement for covered  
9 dental services rendered under this provision.

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

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

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

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

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

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

26 (A) A baseline mammogram for individuals 35 to 39

1 years of age.

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

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

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

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

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

22 The Department shall not impose a deductible, coinsurance,  
23 copayment, or any other cost-sharing requirement on the  
24 coverage provided under this paragraph; except that this  
25 sentence does not apply to coverage of diagnostic mammograms  
26 to the extent such coverage would disqualify a high-deductible

1 health plan from eligibility for a health savings account  
2 pursuant to Section 223 of the Internal Revenue Code (26  
3 U.S.C. 223).

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

8 For purposes of this Section:

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

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

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

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

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

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

22           On and after January 1, 2012, providers participating in a  
23 quality improvement program approved by the Department shall  
24 be reimbursed for screening and diagnostic mammography at the  
25 same rate as the Medicare program's rates, including the  
26 increased reimbursement for digital mammography and, after

1 January 1, 2023 (the effective date of Public Act 102-1018),  
2 breast tomosynthesis.

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

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

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

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

26 The Department shall establish a methodology to remind

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

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

15 The Department shall devise a means of case-managing or  
16 patient navigation for beneficiaries diagnosed with breast  
17 cancer. This program shall initially operate as a pilot  
18 program in areas of the State with the highest incidence of  
19 mortality related to breast cancer. At least one pilot program  
20 site shall be in the metropolitan Chicago area and at least one  
21 site shall be outside the metropolitan Chicago area. On or  
22 after July 1, 2016, the pilot program shall be expanded to  
23 include one site in western Illinois, one site in southern  
24 Illinois, one site in central Illinois, and 4 sites within  
25 metropolitan Chicago. An evaluation of the pilot program shall  
26 be carried out measuring health outcomes and cost of care for



1 those served by the pilot program compared to similarly  
2 situated patients who are not served by the pilot program.

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

11 The Department shall provide coverage and reimbursement  
12 for a human papillomavirus (HPV) vaccine that is approved for  
13 marketing by the federal Food and Drug Administration for all  
14 persons between the ages of 9 and 45. Subject to federal  
15 approval, the Department shall provide coverage and  
16 reimbursement for a human papillomavirus (HPV) vaccine for  
17 persons of the age of 46 and above who have been diagnosed with  
18 cervical dysplasia with a high risk of recurrence or  
19 progression. The Department shall disallow any  
20 preauthorization requirements for the administration of the  
21 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, or  
13 post-adjudicated predictive modeling with an integrated case  
14 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 ~~fee for service~~ and managed  
11 care medical assistance programs for persons who are otherwise  
12 eligible for medical assistance under this Article and shall  
13 not be subject to any (1) utilization control, other than  
14 those established under the American Society of Addiction  
15 Medicine patient placement criteria, (2) prior authorization  
16 mandate, or (3) 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) and subject to federal approval, acupuncture  
26 services performed by an acupuncturist licensed under the

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

7 Notwithstanding any other provision of this Code, the  
8 medical assistance program shall, subject to appropriation and  
9 federal approval, reimburse hospitals for costs associated  
10 with a newborn screening test for the presence of  
11 metachromatic leukodystrophy, as required under the Newborn  
12 Metabolic Screening Act, at a rate not less than the fee  
13 charged by the Department of Public Health. The Department  
14 shall seek federal approval before the implementation of the  
15 newborn screening test fees by the Department of Public  
16 Health.

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

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

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

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

17 ARTICLE 95.

18 Section 95-5. The Specialized Mental Health Rehabilitation  
19 Act of 2013 is amended by changing Section 5-107 as follows:

20 (210 ILCS 49/5-107)

21 Sec. 5-107. Quality of life enhancement. Beginning on July  
22 1, 2019, for improving the quality of life and the quality of  
23 care, an additional payment shall be awarded to a facility for

1 their single occupancy rooms. This payment shall be in  
2 addition to the rate for recovery and rehabilitation. The  
3 additional rate for single room occupancy shall be no less  
4 than \$10 per day, per single room occupancy. The Department of  
5 Healthcare and Family Services shall adjust payment to  
6 Medicaid managed care entities to cover these costs. Beginning  
7 July 1, 2022, for improving the quality of life and the quality  
8 of care, a payment of no less than \$5 per day, per single room  
9 occupancy shall be added to the existing \$10 additional per  
10 day, per single room occupancy rate for a total of at least \$15  
11 per day, per single room occupancy. For improving the quality  
12 of life and the quality of care, on January 1, 2024, a payment  
13 of no less than \$10.50 per day, per single room occupancy shall  
14 be added to the existing \$15 additional per day, per single  
15 room occupancy rate for a total of at least \$25.50 per day, per  
16 single room occupancy. For improving the quality of life and  
17 the quality of care, beginning on January 1, 2025, a payment of  
18 no less than \$10 per day, per single room occupancy shall be  
19 added to the existing \$25.50 additional per day, per single  
20 room occupancy rate for a total of at least \$35.50 per day, per  
21 single room occupancy. Beginning July 1, 2022, for improving  
22 the quality of life and the quality of care, an additional  
23 payment shall be awarded to a facility for its dual-occupancy  
24 rooms. This payment shall be in addition to the rate for  
25 recovery and rehabilitation. The additional rate for  
26 dual-occupancy rooms shall be no less than \$10 per day, per



1 Medicaid-occupied bed, in each dual-occupancy room. Beginning  
2 January 1, 2024, for improving the quality of life and the  
3 quality of care, a payment of no less than \$4.50 per day, per  
4 dual-occupancy room shall be added to the existing \$10  
5 additional per day, per dual-occupancy room rate for a total  
6 of at least \$14.50, per Medicaid-occupied bed, in each  
7 dual-occupancy room. Beginning January 1, 2025, for improving  
8 the quality of life and the quality of care, a payment of no  
9 less than \$8.75 per day, per dual-occupancy room shall be  
10 added to the existing \$14.50 additional per day, per  
11 dual-occupancy room rate for a total of at least \$23.25, per  
12 Medicaid-occupied bed, in each dual-occupancy room. The  
13 Department of Healthcare and Family Services shall adjust  
14 payment to Medicaid managed care entities to cover these  
15 costs. As used in this Section, "dual-occupancy room" means a  
16 room that contains 2 resident beds.  
17 (Source: P.A. 102-699, eff. 4-19-22; 103-102, eff. 1-1-24.)

18 ARTICLE 100.

19 Section 100-5. The Illinois Public Aid Code is amended by  
20 changing Section 5-5.01a as follows:

21 (305 ILCS 5/5-5.01a)

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

23 (a) The Department shall establish and provide oversight

1 for a program of supportive living facilities that seek to  
2 promote resident independence, dignity, respect, and  
3 well-being in the most cost-effective manner.

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

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

15 (b) Beginning July 1, 2014, subject to federal approval,  
16 the Medicaid rates for supportive living facilities shall be  
17 equal to the supportive living facility Medicaid rate  
18 effective on June 30, 2014 increased by 8.85%. Once the  
19 assessment imposed at Article V-G of this Code is determined  
20 to be a permissible tax under Title XIX of the Social Security  
21 Act, the Department shall increase the Medicaid rates for  
22 supportive living facilities effective on July 1, 2014 by  
23 9.09%. The Department shall apply this increase retroactively  
24 to coincide with the imposition of the assessment in Article  
25 V-G of this Code in accordance with the approval for federal  
26 financial participation by the Centers for Medicare and

1 Medicaid Services.

2 The Medicaid rates for supportive living facilities  
3 effective on July 1, 2017 must be equal to the rates in effect  
4 for supportive living facilities on June 30, 2017 increased by  
5 2.8%.

6 The Medicaid rates for supportive living facilities  
7 effective on July 1, 2018 must be equal to the rates in effect  
8 for supportive living facilities on June 30, 2018.

9 Subject to federal approval, the Medicaid rates for  
10 supportive living services on and after July 1, 2019 must be at  
11 least 54.3% of the average total nursing facility services per  
12 diem for the geographic areas defined by the Department while  
13 maintaining the rate differential for dementia care and must  
14 be updated whenever the total nursing facility service per  
15 diems are updated. Beginning July 1, 2022, upon the  
16 implementation of the Patient Driven Payment Model, Medicaid  
17 rates for supportive living services must be at least 54.3% of  
18 the average total nursing services per diem rate for the  
19 geographic areas. For purposes of this provision, the average  
20 total nursing services per diem rate shall include all add-ons  
21 for nursing facilities for the geographic area provided for in  
22 Section 5-5.2. The rate differential for dementia care must be  
23 maintained in these rates and the rates shall be updated  
24 whenever nursing facility per diem rates are updated.

25 Subject to federal approval, beginning January 1, 2024,  
26 the dementia care rate for supportive living services must be

1 no less than the non-dementia care supportive living services  
2 rate multiplied by 1.5.

3 (c) The Department may adopt rules to implement this  
4 Section. Rules that establish or modify the services,  
5 standards, and conditions for participation in the program  
6 shall be adopted by the Department in consultation with the  
7 Department on Aging, the Department of Rehabilitation  
8 Services, and the Department of Mental Health and  
9 Developmental Disabilities (or their successor agencies).

10 (d) Subject to federal approval by the Centers for  
11 Medicare and Medicaid Services, the Department shall accept  
12 for consideration of certification under the program any  
13 application for a site or building where distinct parts of the  
14 site or building are designated for purposes other than the  
15 provision of supportive living services, but only if:

16 (1) those distinct parts of the site or building are  
17 not designated for the purpose of providing assisted  
18 living services as required under the Assisted Living and  
19 Shared Housing Act;

20 (2) those distinct parts of the site or building are  
21 completely separate from the part of the building used for  
22 the provision of supportive living program services,  
23 including separate entrances;

24 (3) those distinct parts of the site or building do  
25 not share any common spaces with the part of the building  
26 used for the provision of supportive living program

1 services; and

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

5 (e) Facilities or distinct parts of facilities which are  
6 selected as supportive living facilities and are in good  
7 standing with the Department's rules are exempt from the  
8 provisions of the Nursing Home Care Act and the Illinois  
9 Health Facilities Planning Act.

10 (f) Section 9817 of the American Rescue Plan Act of 2021  
11 (Public Law 117-2) authorizes a 10% enhanced federal medical  
12 assistance percentage for supportive living services for a  
13 12-month period from April 1, 2021 through March 31, 2022.  
14 Subject to federal approval, including the approval of any  
15 necessary waiver amendments or other federally required  
16 documents or assurances, for a 12-month period the Department  
17 must pay a supplemental \$26 per diem rate to all supportive  
18 living facilities with the additional federal financial  
19 participation funds that result from the enhanced federal  
20 medical assistance percentage from April 1, 2021 through March  
21 31, 2022. The Department may issue parameters around how the  
22 supplemental payment should be spent, including quality  
23 improvement activities. The Department may alter the form,  
24 methods, or timeframes concerning the supplemental per diem  
25 rate to comply with any subsequent changes to federal law,  
26 changes made by guidance issued by the federal Centers for

1 Medicare and Medicaid Services, or other changes necessary to  
2 receive the enhanced federal medical assistance percentage.

3 (g) All applications for the expansion of supportive  
4 living dementia care settings involving sites not approved by  
5 the Department by January 1, 2024 ~~on the effective date of this~~  
6 ~~amendatory Act of the 103rd General Assembly~~ may allow new  
7 elderly non-dementia units in addition to new dementia care  
8 units. The Department may approve such applications only if  
9 the application has: (1) no more than one non-dementia care  
10 unit for each dementia care unit and (2) the site is not  
11 located within 4 miles of an existing supportive living  
12 program site in Cook County (including the City of Chicago),  
13 not located within 12 miles of an existing supportive living  
14 program site in Alexander, Bond, Boone, Calhoun, Champaign,  
15 Clinton, DeKalb, DuPage, Fulton, Grundy, Henry, Jackson,  
16 Jersey, Johnson, Kane, Kankakee, Kendall, Lake, Macon,  
17 Macoupin, Madison, Marshall, McHenry, McLean, Menard, Mercer,  
18 Monroe, Peoria, Piatt, Rock Island, Sangamon, Stark, St.  
19 Clair, Tazewell, Vermilion, Will, Williamson, Winnebago, or  
20 Woodford counties ~~County, Kane County, Lake County, McHenry~~  
21 ~~County, or Will County~~, or not located within 25 miles of an  
22 existing supportive living program site in any other county.

23 (Source: P.A. 102-43, eff. 7-6-21; 102-699, eff. 4-19-22;  
24 103-102, Article 20, Section 20-5, eff. 1-1-24; 103-102,  
25 Article 100, Section 100-5, eff. 1-1-24; revised 12-15-23.)

## 1 ARTICLE 105.

2 Section 105-5. The Illinois Public Aid Code is amended by  
3 changing Section 5-36 as follows:

4 (305 ILCS 5/5-36)

5 Sec. 5-36. Pharmacy benefits.

6 (a)(1) The Department may enter into a contract with a  
7 third party on a fee-for-service reimbursement model for the  
8 purpose of administering pharmacy benefits as provided in this  
9 Section for members not enrolled in a Medicaid managed care  
10 organization; however, these services shall be approved by the  
11 Department. The Department shall ensure coordination of care  
12 between the third-party administrator and managed care  
13 organizations as a consideration in any contracts established  
14 in accordance with this Section. Any managed care techniques,  
15 principles, or administration of benefits utilized in  
16 accordance with this subsection shall comply with State law.

17 (2) The following shall apply to contracts between  
18 entities contracting relating to the Department's third-party  
19 administrators and pharmacies:

20 (A) the Department shall approve any contract between  
21 a third-party administrator and a pharmacy;

22 (B) the Department's third-party administrator shall  
23 not change the terms of a contract between a third-party  
24 administrator and a pharmacy without written approval by

1 the Department; and

2 (C) the Department's third-party administrator shall  
3 not create, modify, implement, or indirectly establish any  
4 fee on a pharmacy, pharmacist, or a recipient of medical  
5 assistance without written approval by the Department.

6 (b) The provisions of this Section shall not apply to  
7 outpatient pharmacy services provided by a health care  
8 facility registered as a covered entity pursuant to 42 U.S.C.  
9 256b or any pharmacy owned by or contracted with the covered  
10 entity. A Medicaid managed care organization shall, either  
11 directly or through a pharmacy benefit manager, administer and  
12 reimburse outpatient pharmacy claims submitted by a health  
13 care facility registered as a covered entity pursuant to 42  
14 U.S.C. 256b, its owned pharmacies, and contracted pharmacies  
15 in accordance with the contractual agreements the Medicaid  
16 managed care organization or its pharmacy benefit manager has  
17 with such facilities and pharmacies and in accordance with  
18 subsection (h-5).

19 (b-5) Any pharmacy benefit manager that contracts with a  
20 Medicaid managed care organization to administer and reimburse  
21 pharmacy claims as provided in this Section must be registered  
22 with the Director of Insurance in accordance with Section  
23 513b2 of the Illinois Insurance Code.

24 (c) On at least an annual basis, the Director of the  
25 Department of Healthcare and Family Services shall submit a  
26 report beginning no later than one year after January 1, 2020



1 (the effective date of Public Act 101-452) that provides an  
2 update on any contract, contract issues, formulary, dispensing  
3 fees, and maximum allowable cost concerns regarding a  
4 third-party administrator and managed care. The requirement  
5 for reporting to the General Assembly shall be satisfied by  
6 filing copies of the report with the Speaker, the Minority  
7 Leader, and the Clerk of the House of Representatives and with  
8 the President, the Minority Leader, and the Secretary of the  
9 Senate. The Department shall take care that no proprietary  
10 information is included in the report required under this  
11 Section.

12 (d) A pharmacy benefit manager shall notify the Department  
13 in writing of any activity, policy, or practice of the  
14 pharmacy benefit manager that directly or indirectly presents  
15 a conflict of interest that interferes with the discharge of  
16 the pharmacy benefit manager's duty to a managed care  
17 organization to exercise its contractual duties. "Conflict of  
18 interest" shall be defined by rule by the Department.

19 (e) A pharmacy benefit manager shall, upon request,  
20 disclose to the Department the following information:

21 (1) whether the pharmacy benefit manager has a  
22 contract, agreement, or other arrangement with a  
23 pharmaceutical manufacturer to exclusively dispense or  
24 provide a drug to a managed care organization's enrollees,  
25 and the aggregate amounts of consideration of economic  
26 benefits collected or received pursuant to that

1 arrangement;

2 (2) the percentage of claims payments made by the  
3 pharmacy benefit manager to pharmacies owned, managed, or  
4 controlled by the pharmacy benefit manager or any of the  
5 pharmacy benefit manager's management companies, parent  
6 companies, subsidiary companies, or jointly held  
7 companies;

8 (3) the aggregate amount of the fees or assessments  
9 imposed on, or collected from, pharmacy providers; ~~and~~

10 (4) the average annualized percentage of revenue  
11 collected by the pharmacy benefit manager as a result of  
12 each contract it has executed with a managed care  
13 organization contracted by the Department to provide  
14 medical assistance benefits which is not paid by the  
15 pharmacy benefit manager to pharmacy providers and  
16 pharmaceutical manufacturers or labelers or in order to  
17 perform administrative functions pursuant to its contracts  
18 with managed care organizations; -

19 (5) the total number of prescriptions dispensed under  
20 each contract the pharmacy benefit manager has with a  
21 managed care organization (MCO) contracted by the  
22 Department to provide medical assistance benefits;

23 (6) the aggregate wholesale acquisition cost for drugs  
24 that were dispensed to enrollees in each MCO with which  
25 the pharmacy benefit manager has a contract by any  
26 pharmacy owned, managed, or controlled by the pharmacy

1 benefit manager or any of the pharmacy benefit manager's  
2 management companies, parent companies, subsidiary  
3 companies, or jointly-held companies;

4 (7) the aggregate amount of administrative fees that  
5 the pharmacy benefit manager received from all  
6 pharmaceutical manufacturers for prescriptions dispensed  
7 to MCO enrollees;

8 (8) for each MCO with which the pharmacy benefit  
9 manager has a contract, the aggregate amount of payments  
10 received by the pharmacy benefit manager from the MCO;

11 (9) for each MCO with which the pharmacy benefit  
12 manager has a contract, the aggregate amount of  
13 reimbursements the pharmacy benefit manager paid to  
14 contracting pharmacies; and

15 (10) any other information considered necessary by the  
16 Department.

17 (f) The information disclosed under subsection (e) shall  
18 include all retail, mail order, specialty, and compounded  
19 prescription products. All information made available to the  
20 Department under subsection (e) is confidential and not  
21 subject to disclosure under the Freedom of Information Act.  
22 All information made available to the Department under  
23 subsection (e) shall not be reported or distributed in any way  
24 that compromises its competitive, proprietary, or financial  
25 value. The information shall only be used by the Department to  
26 assess the contract, agreement, or other arrangements made

1 between a pharmacy benefit manager and a pharmacy provider,  
2 pharmaceutical manufacturer or labeler, managed care  
3 organization, or other entity, as applicable.

4 (g) A pharmacy benefit manager shall disclose directly in  
5 writing to a pharmacy provider or pharmacy services  
6 administrative organization contracting with the pharmacy  
7 benefit manager of any material change to a contract provision  
8 that affects the terms of the reimbursement, the process for  
9 verifying benefits and eligibility, dispute resolution,  
10 procedures for verifying drugs included on the formulary, and  
11 contract termination at least 30 days prior to the date of the  
12 change to the provision. The terms of this subsection shall be  
13 deemed met if the pharmacy benefit manager posts the  
14 information on a website, viewable by the public. A pharmacy  
15 service administration organization shall notify all contract  
16 pharmacies of any material change, as described in this  
17 subsection, within 2 days of notification. As used in this  
18 Section, "pharmacy services administrative organization" means  
19 an entity operating within the State that contracts with  
20 independent pharmacies to conduct business on their behalf  
21 with third-party payers. A pharmacy services administrative  
22 organization may provide administrative services to pharmacies  
23 and negotiate and enter into contracts with third-party payers  
24 or pharmacy benefit managers on behalf of pharmacies.

25 (h) A pharmacy benefit manager shall not include the  
26 following in a contract with a pharmacy provider:

1           (1) a provision prohibiting the provider from  
2 informing a patient of a less costly alternative to a  
3 prescribed medication; or

4           (2) a provision that prohibits the provider from  
5 dispensing a particular amount of a prescribed medication,  
6 if the pharmacy benefit manager allows that amount to be  
7 dispensed through a pharmacy owned or controlled by the  
8 pharmacy benefit manager, unless the prescription drug is  
9 subject to restricted distribution by the United States  
10 Food and Drug Administration or requires special handling,  
11 provider coordination, or patient education that cannot be  
12 provided by a retail pharmacy.

13           (h-5) Unless required by law, a Medicaid managed care  
14 organization or pharmacy benefit manager administering or  
15 managing benefits on behalf of a Medicaid managed care  
16 organization shall not refuse to contract with a 340B entity  
17 or 340B pharmacy for refusing to accept less favorable payment  
18 terms or reimbursement methodologies when compared to  
19 similarly situated non-340B entities and shall not include in  
20 a contract with a 340B entity or 340B pharmacy a provision  
21 that:

22           (1) imposes any fee, chargeback, or rate adjustment  
23 that is not similarly imposed on similarly situated  
24 pharmacies that are not 340B entities or 340B pharmacies;

25           (2) imposes any fee, chargeback, or rate adjustment  
26 that exceeds the fee, chargeback, or rate adjustment that

1 is not similarly imposed on similarly situated pharmacies  
2 that are not 340B entities or 340B pharmacies;

3 (3) prevents or interferes with an individual's choice  
4 to receive a prescription drug from a 340B entity or 340B  
5 pharmacy through any legally permissible means;

6 (4) excludes a 340B entity or 340B pharmacy from a  
7 pharmacy network on the basis of whether the 340B entity  
8 or 340B pharmacy participates in the 340B drug discount  
9 program;

10 (5) prevents a 340B entity or 340B pharmacy from using  
11 a drug purchased under the 340B drug discount program so  
12 long as the drug recipient is a patient of the 340B entity;  
13 nothing in this Section exempts a 340B pharmacy from  
14 following the Department's preferred drug list or from any  
15 prior approval requirements of the Department or the  
16 Medicaid managed care organization that are imposed on the  
17 drug for all pharmacies; or

18 (6) any other provision that discriminates against a  
19 340B entity or 340B pharmacy by treating a 340B entity or  
20 340B pharmacy differently than non-340B entities or  
21 non-340B pharmacies for any reason relating to the  
22 entity's participation in the 340B drug discount program.

23 A provision that violates this subsection in any contract  
24 between a Medicaid managed care organization or its pharmacy  
25 benefit manager and a 340B entity entered into, amended, or  
26 renewed after July 1, 2022 shall be void and unenforceable.

1 In this subsection (h-5):

2 "340B entity" means a covered entity as defined in 42  
3 U.S.C. 256b(a)(4) authorized to participate in the 340B drug  
4 discount program.

5 "340B pharmacy" means any pharmacy used to dispense 340B  
6 drugs for a covered entity, whether entity-owned or external.

7 (i) Nothing in this Section shall be construed to prohibit  
8 a pharmacy benefit manager from requiring the same  
9 reimbursement and terms and conditions for a pharmacy provider  
10 as for a pharmacy owned, controlled, or otherwise associated  
11 with the pharmacy benefit manager.

12 (j) A pharmacy benefit manager shall establish and  
13 implement a process for the resolution of disputes arising out  
14 of this Section, which shall be approved by the Department.

15 (k) The Department shall adopt rules establishing  
16 reasonable dispensing fees for fee-for-service payments in  
17 accordance with guidance or guidelines from the federal  
18 Centers for Medicare and Medicaid Services.

19 (Source: P.A. 101-452, eff. 1-1-20; 102-558, eff. 8-20-21;  
20 102-778, eff. 7-1-22.)

21 ARTICLE 110.

22 Section 110-5. The Specialized Mental Health  
23 Rehabilitation Act of 2013 is amended by adding Section 5-113  
24 as follows:

1 (210 ILCS 49/5-113 new)

2 Sec. 5-113. Specialized mental health rehabilitation  
3 facility; one payment. Notwithstanding any other provision of  
4 this Act to the contrary, beginning January 1, 2025, there  
5 shall be a separate per diem add-on paid solely and  
6 exclusively to facilities licensed under this Act that are  
7 licensed for only single occupancy rooms and have reduced  
8 their licensed capacity. No facility licensed under this Act  
9 shall be eligible for these payments if the facility contains  
10 any rooms that house more than a single occupant and have  
11 failed to reduce the facilities' licensed capacity.

12 The payment shall be a per diem add-on payment. For  
13 facilities with less than 100 licensed beds, the add-on  
14 payment shall result in a rate not less than \$240 per day. For  
15 facilities with 100 licensed beds to 130 licensed beds, the  
16 add-on payment shall result in a rate not less than \$230 per  
17 day. For facilities with more than 130 licensed beds, the  
18 add-on payment shall result in a rate of not less than \$220 per  
19 day. All add-on rates shall be based upon the new licensed  
20 capacity.

21 Any additional payments in effect after January 1, 2025  
22 under Section 5-107 shall be paid in addition to the amounts  
23 listed in this Section. Facilities receiving payments under  
24 this Section shall receive payment as prescribed under Section  
25 5-101.



1

ARTICLE 115.

2

Section 115-5. The Illinois Public Aid Code is amended by adding Section 5-53 as follows:

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4

(305 ILCS 5/5-53 new)

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Sec. 5-53. Coverage for self-measure blood pressure monitoring services. Subject to federal approval and notwithstanding any other provision of this Code, for services on and after January 1, 2025, the following self-measure blood pressure monitoring services shall be covered and reimbursed under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article:

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(1) patient education and training services on the set-up and use of a self-measure blood pressure measurement device validated for clinical accuracy and device calibration; and

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(2) separate self-measurement readings and the collection of data reports by the patient or caregiver to the health care provider in order to communicate blood pressure readings and create or modify treatment plans.

20

ARTICLE 120.

21

(305 ILCS 5/15-6 rep.)

1 Section 120-5. The Illinois Public Aid Code is amended by  
2 repealing Section 15-6.

3 Article 125.

4 Section 125-5. The State Finance Act is amended by  
5 changing Section 5.797 as follows:

6 (30 ILCS 105/5.797)

7 Sec. 5.797. The Electronic Health Record Incentive Fund.  
8 This Section is repealed on January 1, 2025.

9 (Source: P.A. 97-169, eff. 7-22-11; 97-813, eff. 7-13-12.)

10 Section 125-10. The Illinois Public Aid Code is amended by  
11 changing Section 12-10.6a as follows:

12 (305 ILCS 5/12-10.6a)

13 Sec. 12-10.6a. The Electronic Health Record Incentive  
14 Fund.

15 (a) The Electronic Health Record Incentive Fund is a  
16 special fund created in the State treasury. All federal moneys  
17 received by the Department of Healthcare and Family Services  
18 for payments to qualifying health care providers to encourage  
19 the adoption and use of certified electronic health records  
20 technology pursuant to paragraph 1903(t)(1) of the Social  
21 Security Act, shall be deposited into the Fund.

1 (b) Disbursements from the Fund shall be made at the  
2 direction of the Director of Healthcare and Family Services to  
3 qualifying health care providers, in amounts established under  
4 applicable federal regulation (42 CFR 495 et seq.), in order  
5 to encourage the adoption and use of certified electronic  
6 health records technology.

7 (c) On January 1, 2025, or as soon thereafter as  
8 practical, the State Comptroller shall direct and the State  
9 Treasurer shall transfer the remaining balance from the  
10 Electronic Health Record Incentive Fund into the Public Aid  
11 Recoveries Trust Fund. Upon completion of the transfer, the  
12 Electronic Health Record Incentive Fund is dissolved, and any  
13 future deposits due to that Fund and any outstanding  
14 obligations or liabilities of that Fund shall pass to the  
15 Public Aid Recoveries Trust Fund.

16 (Source: P.A. 97-169, eff. 7-22-11.)

17 Article 130.

18 (30 ILCS 105/5.836 rep.)

19 Section 130-5. The State Finance Act is amended by  
20 repealing Section 5.836.

21 (305 ILCS 5/5-31 rep.)

22 (305 ILCS 5/5-32 rep.)

23 Section 130-10. The Illinois Public Aid Code is amended by

1 repealing Sections 5-31 and 5-32.

2 Article 135.

3 Section 135-5. The State Finance Act is amended by  
4 changing Section 5.481 as follows:

5 (30 ILCS 105/5.481)

6 Sec. 5.481. The Juvenile Rehabilitation Services Medicaid  
7 Matching Fund. This Section is repealed on January 1, 2026.

8 (Source: P.A. 90-587, eff. 7-1-98.)

9 Section 135-10. The Illinois Public Aid Code is amended by  
10 changing Sections 12-9 and 12-10.4 as follows:

11 (305 ILCS 5/12-9) (from Ch. 23, par. 12-9)

12 Sec. 12-9. Public Aid Recoveries Trust Fund; uses. The  
13 Public Aid Recoveries Trust Fund shall consist of (1)  
14 recoveries by the Department of Healthcare and Family Services  
15 (formerly Illinois Department of Public Aid) authorized by  
16 this Code in respect to applicants or recipients under  
17 Articles III, IV, V, and VI, including recoveries made by the  
18 Department of Healthcare and Family Services (formerly  
19 Illinois Department of Public Aid) from the estates of  
20 deceased recipients, (2) recoveries made by the Department of  
21 Healthcare and Family Services (formerly Illinois Department

1 of Public Aid) in respect to applicants and recipients under  
2 the Children's Health Insurance Program Act, and the Covering  
3 ALL KIDS Health Insurance Act, (2.5) recoveries made by the  
4 Department of Healthcare and Family Services in connection  
5 with the imposition of an administrative penalty as provided  
6 under Section 12-4.45, (3) federal funds received on behalf of  
7 and earned by State universities, other State agencies or  
8 departments, and local governmental entities for services  
9 provided to applicants or recipients covered under this Code,  
10 the Children's Health Insurance Program Act, and the Covering  
11 ALL KIDS Health Insurance Act, (3.5) federal financial  
12 participation revenue related to eligible disbursements made  
13 by the Department of Healthcare and Family Services from  
14 appropriations required by this Section, and (4) all other  
15 moneys received to the Fund, including interest thereon. The  
16 Fund shall be held as a special fund in the State Treasury.

17 Disbursements from this Fund shall be only (1) for the  
18 reimbursement of claims collected by the Department of  
19 Healthcare and Family Services (formerly Illinois Department  
20 of Public Aid) through error or mistake, (2) for payment to  
21 persons or agencies designated as payees or co-payees on any  
22 instrument, whether or not negotiable, delivered to the  
23 Department of Healthcare and Family Services (formerly  
24 Illinois Department of Public Aid) as a recovery under this  
25 Section, such payment to be in proportion to the respective  
26 interests of the payees in the amount so collected, (3) for

1 payments to the Department of Human Services for collections  
2 made by the Department of Healthcare and Family Services  
3 (formerly Illinois Department of Public Aid) on behalf of the  
4 Department of Human Services under this Code, the Children's  
5 Health Insurance Program Act, and the Covering ALL KIDS Health  
6 Insurance Act, (4) for payment of administrative expenses  
7 incurred in performing the activities authorized under this  
8 Code, the Children's Health Insurance Program Act, and the  
9 Covering ALL KIDS Health Insurance Act, (5) for payment of  
10 fees to persons or agencies in the performance of activities  
11 pursuant to the collection of monies owed the State that are  
12 collected under this Code, the Children's Health Insurance  
13 Program Act, and the Covering ALL KIDS Health Insurance Act,  
14 (6) for payments of any amounts which are reimbursable to the  
15 federal government which are required to be paid by State  
16 warrant by either the State or federal government, and (7) for  
17 payments to State universities, other State agencies or  
18 departments, and local governmental entities of federal funds  
19 for services provided to applicants or recipients covered  
20 under this Code, the Children's Health Insurance Program Act,  
21 and the Covering ALL KIDS Health Insurance Act. Disbursements  
22 from this Fund for purposes of items (4) and (5) of this  
23 paragraph shall be subject to appropriations from the Fund to  
24 the Department of Healthcare and Family Services (formerly  
25 Illinois Department of Public Aid).

26 The balance in this Fund after payment therefrom of any

1 amounts reimbursable to the federal government, and minus the  
2 amount ~~reasonably~~ anticipated to be needed to make the  
3 disbursements authorized by this Section ~~during the current~~  
4 ~~and following 3 calendar months~~, shall be certified by the  
5 Director of Healthcare and Family Services and transferred by  
6 the State Comptroller to the Drug Rebate Fund or the  
7 Healthcare Provider Relief Fund in the State Treasury, as  
8 appropriate, on at least an annual basis by June 30th of each  
9 fiscal year. The Director of Healthcare and Family Services  
10 may certify and the State Comptroller shall transfer to the  
11 Drug Rebate Fund or the Healthcare Provider Relief Fund  
12 amounts on a more frequent basis.

13 ~~On July 1, 1999, the State Comptroller shall transfer the~~  
14 ~~sum of \$5,000,000 from the Public Aid Recoveries Trust Fund~~  
15 ~~(formerly the Public Assistance Recoveries Trust Fund) into~~  
16 ~~the DHS Recoveries Trust Fund.~~

17 (Source: P.A. 97-647, eff. 1-1-12; 97-689, eff. 6-14-12;  
18 98-130, eff. 8-2-13; 98-651, eff. 6-16-14.)

19 (305 ILCS 5/12-10.4)

20 Sec. 12-10.4. Juvenile Rehabilitation Services Medicaid  
21 Matching Fund. There is created in the State Treasury the  
22 Juvenile Rehabilitation Services Medicaid Matching Fund.  
23 Deposits to this Fund shall consist of all moneys received  
24 from the federal government for behavioral health services  
25 secured by counties pursuant to an agreement with the

1 Department of Healthcare and Family Services with respect to  
2 Title XIX of the Social Security Act or under the Children's  
3 Health Insurance Program pursuant to the Children's Health  
4 Insurance Program Act and Title XXI of the Social Security Act  
5 for minors who are committed to mental health facilities by  
6 the Illinois court system and for residential placements  
7 secured by the Department of Juvenile Justice for minors as a  
8 condition of their aftercare release.

9 Disbursements from the Fund shall be made, subject to  
10 appropriation, by the Department of Healthcare and Family  
11 Services for grants to the Department of Juvenile Justice and  
12 those counties which secure behavioral health services ordered  
13 by the courts and which have an interagency agreement with the  
14 Department and submit detailed bills according to standards  
15 determined by the Department.

16 On January 1, 2026, or as soon thereafter as practical,  
17 the State Comptroller shall direct and the State Treasurer  
18 shall transfer the remaining balance from the Juvenile  
19 Rehabilitation Services Medicaid Matching Fund into the Public  
20 Aid Recoveries Trust Fund. Upon completion of the transfer,  
21 the Juvenile Rehabilitation Services Medicaid Matching Fund is  
22 dissolved, and any future deposits due to that Fund and any  
23 outstanding obligations or liabilities of that Fund shall pass  
24 to the Public Aid Recoveries Trust Fund.

25 (Source: P.A. 98-558, eff. 1-1-14.)



1 Article 140.

2 (30 ILCS 105/5.856 rep.)

3 Section 140-5. The State Finance Act is amended by  
4 repealing Section 5.856.

5 (305 ILCS 5/Art. V-G rep.)

6 Section 140-10. The Illinois Public Aid Code is amended by  
7 repealing Article V-G.

8 Article 145.

9 Section 145-5. The State Finance Act is amended by  
10 changing Sections 5.409 and 6z-40 as follows:

11 (30 ILCS 105/5.409)

12 Sec. 5.409. The Provider Inquiry Trust Fund. This Section  
13 is repealed on January 1, 2025.

14 (Source: P.A. 89-21, eff. 7-1-95.)

15 (30 ILCS 105/6z-40)

16 Sec. 6z-40. Provider Inquiry Trust Fund. The Provider  
17 Inquiry Trust Fund is created as a special fund in the State  
18 treasury. Payments into the fund shall consist of fees or  
19 other moneys owed by providers of services or their agents,  
20 including other State agencies, for access to and utilization

1 of Illinois Department of Healthcare and Family Services  
2 ~~Public Aid~~ eligibility files to verify eligibility of clients,  
3 bills for services, or other similar, related uses.  
4 Disbursements from the fund shall consist of payments to the  
5 Department of Innovation and Technology ~~Central Management~~  
6 ~~Services~~ for communication and statistical services and for  
7 payments for administrative expenses incurred by the Illinois  
8 Department of Healthcare and Family Services ~~Public Aid~~ in the  
9 operation of the fund.

10 On January 1, 2025, or as soon thereafter as practical,  
11 the State Comptroller shall direct and the State Treasurer  
12 shall transfer the remaining balance from the Provider Inquiry  
13 Trust Fund into the Healthcare Provider Relief Fund. Upon  
14 completion of the transfer, the Provider Inquiry Trust Fund is  
15 dissolved, and any future deposits due to that Fund and any  
16 outstanding obligations or liabilities of that Fund shall pass  
17 to the Healthcare Provider Relief Fund.

18 (Source: P.A. 94-91, eff. 7-1-05.)

19 ARTICLE 150.

20 Section 150-5. The Illinois Public Aid Code is amended by  
21 changing Section 5-30.1 and by adding Section 5-30.18 as  
22 follows:

23 (305 ILCS 5/5-30.1)

1           Sec. 5-30.1. Managed care protections.

2           (a) As used in this Section:

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

6           "Emergency services" means health care items and services,  
7 including inpatient and outpatient hospital services,  
8 furnished or required to evaluate and stabilize an emergency  
9 medical condition. "Emergency services" include inpatient  
10 stabilization services furnished during the inpatient  
11 stabilization period. "Emergency services" do not include  
12 post-stabilization medical services. ~~include:~~

13                 ~~(1) emergency services, as defined by Section 10 of~~  
14 ~~the Managed Care Reform and Patient Rights Act;~~

15                 ~~(2) emergency medical screening examinations, as~~  
16 ~~defined by Section 10 of the Managed Care Reform and~~  
17 ~~Patient Rights Act;~~

18                 ~~(3) post stabilization medical services, as defined by~~  
19 ~~Section 10 of the Managed Care Reform and Patient Rights~~  
20 ~~Act; and~~

21                 ~~(4) emergency medical conditions, as defined by~~  
22 ~~Section 10 of the Managed Care Reform and Patient Rights~~  
23 ~~Act.~~

24           "Emergency medical condition" means a medical condition  
25 manifesting itself by acute symptoms of sufficient severity,  
26 regardless of the final diagnosis given, such that a prudent

1 layperson, who possesses an average knowledge of health and  
2 medicine, could reasonably expect the absence of immediate  
3 medical attention to result in:

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

7 (2) serious impairment to bodily functions;

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

9 (4) inadequately controlled pain; or

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

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

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

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

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

1 program.

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

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

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

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

23 "Service authorization determination" means a decision  
24 made by a service authorization program in advance of,  
25 concurrent to, or after the provision of a health care service  
26 to approve, change the level of care, partially deny, deny, or

1 otherwise limit coverage and reimbursement for a health care  
2 service upon review of a service authorization request.

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

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

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

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

25 (c) An MCO shall pay any provider of emergency services,  
26 including for inpatient stabilization services provided during

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

11 (d) (Blank). ~~An MCO shall pay for all post-stabilization~~  
12 ~~services as a covered service in any of the following~~  
13 ~~situations:~~

14 ~~(1) the MCO authorized such services;~~

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

19 ~~(3) the MCO did not respond to a request to authorize~~  
20 ~~such services within one hour;~~

21 ~~(4) the MCO could not be contacted; or~~

22 ~~(5) the MCO and the treating provider, if the treating~~  
23 ~~provider is a non-affiliated provider, could not reach an~~  
24 ~~agreement concerning the enrollee's care and an affiliated~~  
25 ~~provider was unavailable for a consultation, in which case~~  
26 ~~the MCO must pay for such services rendered by the~~

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

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

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

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



1           MCO that the patient has been admitted to a hospital  
2           inpatient level of care.

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

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

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

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

24           (4) The MCO shall not condition coverage for emergency  
25           services on the treating provider notifying the MCO of the  
26           enrollee's emergency medical screening examination and

1 treatment within 10 days after presentation for emergency  
2 services.

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

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

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

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

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

4 (D) the enrollee is discharged.

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

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

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

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

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

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

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

7 (f) Network adequacy and transparency.

8 (1) The Department shall:

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

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

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

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

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

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

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

21 (g) Timely payment of claims.

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

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

1 receiving that claim.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (B) retroactive prior authorizations; and

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



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

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

7           (g-6) MCO Performance Metrics Report.

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

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

14                   (B) prior authorizations;

15                   (C) grievance and appeals;

16                   (D) utilization statistics;

17                   (E) provider disputes;

18                   (F) provider credentialing; and

19                   (G) member and provider customer service.

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

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

1 identified industry.

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

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

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

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

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

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

14 (A) Premium revenue, with appropriate adjustments.

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

17 (i) Direct paid claims.

18 (ii) Subcapitation payments.

19 (iii) Other claim payments.

20 (iv) Direct reserves.

21 (v) Gross recoveries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 (2) Prior to July 1, 2025, the Department shall in  
21 accordance with the Illinois Administrative Procedure Act  
22 adopt rules which govern MCO practices for dates of  
23 services on and after July 1, 2025, as follows:

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

26 (B) procedures that, due to medical complexity,

1 must be reimbursed under the applicable inpatient  
2 methodology, when provided in the inpatient setting  
3 and billed as an inpatient service;

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

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

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

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

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

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

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

24 (B) an analysis that compares and contrasts the  
25 Medicaid MCO's service authorization determination  
26 outcomes to the outcomes of each other MCO plan and the



1       State's fee-for-service program model to evaluate  
2       whether service authorization determinations are being  
3       made consistently by all Medicaid MCOs to ensure that  
4       all individuals are being treated in accordance with  
5       equitable standards of care;

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

16      (D) provide a written report to the General  
17      Assembly, detailing the items listed in this  
18      subsection and any other metrics deemed necessary by  
19      the Department, by the second April, following the  
20      effective date of this amendatory Act of the 103rd  
21      General Assembly, and each April thereafter. The  
22      Department shall make this report available within 30  
23      days of delivery to the General Assembly, on its  
24      public facing website.

25       (h) The Department shall not expand mandatory MCO  
26       enrollment into new counties beyond those counties already

1 designated by the Department as of June 1, 2014 for the  
2 individuals whose eligibility for medical assistance is not  
3 the seniors or people with disabilities population until the  
4 Department provides an opportunity for accountable care  
5 entities and MCOs to participate in such newly designated  
6 counties.

7 (h-5) Leading indicator data sharing. By January 1, 2024,  
8 the Department shall obtain input from the Department of Human  
9 Services, the Department of Juvenile Justice, the Department  
10 of Children and Family Services, the State Board of Education,  
11 managed care organizations, providers, and clinical experts to  
12 identify and analyze key indicators from assessments and data  
13 sets available to the Department that can be shared with  
14 managed care organizations and similar care coordination  
15 entities contracted with the Department as leading indicators  
16 for elevated behavioral health crisis risk for children. To  
17 the extent permitted by State and federal law, the identified  
18 leading indicators shall be shared with managed care  
19 organizations and similar care coordination entities  
20 contracted with the Department within 6 months of  
21 identification for the purpose of improving care coordination  
22 with the early detection of elevated risk. Leading indicators  
23 shall be reassessed annually with stakeholder input.

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

1 Act 98-651).

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

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

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

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

25 (Source: P.A. 102-4, eff. 4-27-21; 102-43, eff. 7-6-21;  
26 102-144, eff. 1-1-22; 102-454, eff. 8-20-21; 102-813, eff.

1 5-13-22; 103-546, eff. 8-11-23.)

2 (305 ILCS 5/5-30.18 new)

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

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

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

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

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

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

1 appropriate, and approved for reimbursement as ordered.

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

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

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

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

1 Illinois Administrative Procedure Act, adopt administrative  
2 rules, consistent with this Section, to require each Medicaid  
3 MCO to identify Gold Card providers with such identification  
4 initially being effective for health care services provided on  
5 and after July 1, 2025.

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

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

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

24 (3) The service authorization exemption shall be valid  
25 for at least one year, shall be made by each Medicaid MCO  
26 or its URO, and shall be binding on the Medicaid MCO and

1       its URO.

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

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

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

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

1 year.

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

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

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

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

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



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

2 ARTICLE 155.

3 Section 155-5. The Community-Integrated Living  
4 Arrangements Licensure and Certification Act is amended by  
5 adding Section 13.3 as follows:

6 (210 ILCS 135/13.3 new)

7 Sec. 13.3. Community-integrated living arrangement per  
8 diem reimbursement. As used in this Section, "medical absence"  
9 means a situation in which a resident is temporarily absent  
10 from a community-integrated living arrangement to receive  
11 medical treatment or for other reasons that have been  
12 recommended by third-party medical personnel, including, but  
13 not limited to, hospitalizations, placements in short-term  
14 stabilization homes or State-operated facilities, stays in  
15 nursing facilities, rehabilitation in long-term care  
16 facilities, or other absences for legitimate medical reasons.

17 Beginning January 1, 2025, the Department's Division of  
18 Developmental Disabilities shall provide 100% of the per diem  
19 reimbursement to a 24-hour community-integrated living  
20 arrangement provider for up to 20 days for any resident  
21 requiring a medical absence. During the medical absence, the  
22 provider shall hold the bed for the resident. After the  
23 medical absence, the resident shall return to the

1 community-integrated living arrangement when the resident is  
2 medically able to return in order for the provider to receive  
3 the full per diem reimbursement for the absent days. The per  
4 diem reimbursement shall be in addition to the existing  
5 occupancy factor policy set by the Division of Developmental  
6 Disabilities.

7 ARTICLE 160.

8 Section 160-5. The Illinois Public Aid Code is amended by  
9 adding Section 5-5.12f as follows:

10 (305 ILCS 5/5-5.12f new)

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

13 (a) Notwithstanding any other provision of this Code to  
14 the contrary, except as otherwise provided in subsection (b),  
15 for the purpose of removing barriers to the timely treatment  
16 of serious mental illnesses, prior authorization mandates and  
17 utilization management controls shall not be imposed under the  
18 fee-for-service and managed care medical assistance programs  
19 on any FDA-approved prescription drug that is recognized by a  
20 generally accepted standard medical reference as effective in  
21 the treatment of conditions specified in the most recent  
22 Diagnostic and Statistical Manual of Mental Disorders  
23 published by the American Psychiatric Association if a

1 preferred or non-preferred drug is prescribed to an adult  
2 patient to treat serious mental illness and one of the  
3 following applies:

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

9 (2) the patient has changed insurance coverage and is  
10 stable on the drug that has been previously prescribed and  
11 received prior authorization under the previous source of  
12 coverage; or

13 (3) subject to federal law on maximum dosage limits  
14 and safety edits adopted by the Department's Drug and  
15 Therapeutics Board, including those safety edits and  
16 limits needed to comply with federal requirements  
17 contained in 42 CFR 456.703, the patient has previously  
18 been prescribed and obtained prior authorization for the  
19 drug and the prescription modifies the dosage, dosage  
20 frequency, or both, of the drug as part of the same  
21 treatment for which the drug was previously prescribed.

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

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

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

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

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

13           (1) Delusional Disorder (F22)

14           (2) Brief Psychotic Disorder (F23)

15           (3) Schizophreniform Disorder (F20.81)

16           (4) Schizophrenia (F20.9)

17           (5) Schizoaffective Disorder (F25.x)

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

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

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

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

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

26           (11) Cyclothymic Disorder (F34.0)

- 1           (12) Unspecified Bipolar and Related Disorder (F31.9)  
2           (13) Disruptive Mood Dysregulation Disorder (F34.8)  
3           (14) Major Depressive Disorder Single episode (F32.xx)  
4           (15) Major Depressive Disorder, Recurrent episode  
5           (F33.xx)  
6           (16) Obsessive-Compulsive Disorder (F42)  
7           (17) Posttraumatic Stress Disorder (F43.10)  
8           (18) Anorexia Nervosa (F50.0x)  
9           (19) Bulimia Nervosa (F50.2)  
10           (20) Postpartum Depression (F53.0)  
11           (21) Puerperal Psychosis (F53.1)  
12           (22) Factitious Disorder Imposed on Another (F68.A)  
13           (d) Notwithstanding any other provision of law, nothing in  
14           this Section shall not be construed to conflict with Section  
15           1927(a)(1) and (b)(1)(A) of the federal Social Security Act  
16           and any implementing regulations and agreements.

17   ARTICLE 165.

18           Section 165-5. The Illinois Public Aid Code is amended by  
19           changing Section 5-5.01a as follows:

20           (305 ILCS 5/5-5.01a)

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

22           (a) The Department shall establish and provide oversight  
23           for a program of supportive living facilities that seek to

1 promote resident independence, dignity, respect, and  
2 well-being in the most cost-effective manner.

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

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

14 (b) Beginning July 1, 2014, subject to federal approval,  
15 the Medicaid rates for supportive living facilities shall be  
16 equal to the supportive living facility Medicaid rate  
17 effective on June 30, 2014 increased by 8.85%. Once the  
18 assessment imposed at Article V-G of this Code is determined  
19 to be a permissible tax under Title XIX of the Social Security  
20 Act, the Department shall increase the Medicaid rates for  
21 supportive living facilities effective on July 1, 2014 by  
22 9.09%. The Department shall apply this increase retroactively  
23 to coincide with the imposition of the assessment in Article  
24 V-G of this Code in accordance with the approval for federal  
25 financial participation by the Centers for Medicare and  
26 Medicaid Services.

1           The Medicaid rates for supportive living facilities  
2 effective on July 1, 2017 must be equal to the rates in effect  
3 for supportive living facilities on June 30, 2017 increased by  
4 2.8%.

5           The Medicaid rates for supportive living facilities  
6 effective on July 1, 2018 must be equal to the rates in effect  
7 for supportive living facilities on June 30, 2018.

8           Subject to federal approval, the Medicaid rates for  
9 supportive living services on and after July 1, 2019 must be at  
10 least 54.3% of the average total nursing facility services per  
11 diem for the geographic areas defined by the Department while  
12 maintaining the rate differential for dementia care and must  
13 be updated whenever the total nursing facility service per  
14 diems are updated. Beginning July 1, 2022, upon the  
15 implementation of the Patient Driven Payment Model, Medicaid  
16 rates for supportive living services must be at least 54.3% of  
17 the average total nursing services per diem rate for the  
18 geographic areas. For purposes of this provision, the average  
19 total nursing services per diem rate shall include all add-ons  
20 for nursing facilities for the geographic area provided for in  
21 Section 5-5.2. The rate differential for dementia care must be  
22 maintained in these rates and the rates shall be updated  
23 whenever nursing facility per diem rates are updated.

24           Subject to federal approval, beginning January 1, 2024,  
25 the dementia care rate for supportive living services must be  
26 no less than the non-dementia care supportive living services

1 rate multiplied by 1.5.

2 (c) The Department may adopt rules to implement this  
3 Section. Rules that establish or modify the services,  
4 standards, and conditions for participation in the program  
5 shall be adopted by the Department in consultation with the  
6 Department on Aging, the Department of Rehabilitation  
7 Services, and the Department of Mental Health and  
8 Developmental Disabilities (or their successor agencies).

9 (d) Subject to federal approval by the Centers for  
10 Medicare and Medicaid Services, the Department shall accept  
11 for consideration of certification under the program any  
12 application for a site or building where distinct parts of the  
13 site or building are designated for purposes other than the  
14 provision of supportive living services, but only if:

15 (1) those distinct parts of the site or building are  
16 not designated for the purpose of providing assisted  
17 living services as required under the Assisted Living and  
18 Shared Housing Act;

19 (2) those distinct parts of the site or building are  
20 completely separate from the part of the building used for  
21 the provision of supportive living program services,  
22 including separate entrances;

23 (3) those distinct parts of the site or building do  
24 not share any common spaces with the part of the building  
25 used for the provision of supportive living program  
26 services; and



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

4           (e) Facilities or distinct parts of facilities which are  
5           selected as supportive living facilities and are in good  
6           standing with the Department's rules are exempt from the  
7           provisions of the Nursing Home Care Act and the Illinois  
8           Health Facilities Planning Act.

9           (f) Section 9817 of the American Rescue Plan Act of 2021  
10          (Public Law 117-2) authorizes a 10% enhanced federal medical  
11          assistance percentage for supportive living services for a  
12          12-month period from April 1, 2021 through March 31, 2022.  
13          Subject to federal approval, including the approval of any  
14          necessary waiver amendments or other federally required  
15          documents or assurances, for a 12-month period the Department  
16          must pay a supplemental \$26 per diem rate to all supportive  
17          living facilities with the additional federal financial  
18          participation funds that result from the enhanced federal  
19          medical assistance percentage from April 1, 2021 through March  
20          31, 2022. The Department may issue parameters around how the  
21          supplemental payment should be spent, including quality  
22          improvement activities. The Department may alter the form,  
23          methods, or timeframes concerning the supplemental per diem  
24          rate to comply with any subsequent changes to federal law,  
25          changes made by guidance issued by the federal Centers for  
26          Medicare and Medicaid Services, or other changes necessary to

1 receive the enhanced federal medical assistance percentage.

2 (g) All applications for the expansion of supportive  
3 living dementia care settings involving sites not approved by  
4 the Department on January 1, 2024 (the effective date of  
5 Public Act 103-102) ~~this amendatory Act of the 103rd General~~  
6 ~~Assembly~~ may allow new elderly non-dementia units in addition  
7 to new dementia care units. The Department may approve such  
8 applications only if the application has: (1) no more than one  
9 non-dementia care unit for each dementia care unit and (2) the  
10 site is not located within 4 miles of an existing supportive  
11 living program site in Cook County (including the City of  
12 Chicago), not located within 12 miles of an existing  
13 supportive living program site in DuPage County, Kane County,  
14 Lake County, McHenry County, or Will County, or not located  
15 within 25 miles of an existing supportive living program site  
16 in any other county.

17 (h) As stated in the supportive living program home and  
18 community-based service waiver approved by the federal Centers  
19 for Medicare and Medicaid Services, and beginning July 1,  
20 2025, the Department must maintain the rate add-on implemented  
21 on January 1, 2023 for the provision of 2 meals per day at no  
22 less than \$6.15 per day.

23 (Source: P.A. 102-43, eff. 7-6-21; 102-699, eff. 4-19-22;  
24 103-102, Article 20, Section 20-5, eff. 1-1-24; 103-102,  
25 Article 100, Section 100-5, eff. 1-1-24; revised 12-15-23.)

## 1 ARTICLE 170.

2 Section 170-5. The Illinois Public Aid Code is amended by  
3 adding Section 5-2.06a as follows:

4 (305 ILCS 5/5-2.06a new)

5 Sec. 5-2.06a. Medically fragile children; reimbursement  
6 for legally responsible family caregivers. By January 1, 2025,  
7 the Department of Healthcare and Family Services shall apply  
8 for a Home and Community-Based Services State Plan amendment  
9 and any federal waiver necessary to reimburse legally  
10 responsible family caregivers as providers of personal care or  
11 home health aide services under the Illinois Title XIX State  
12 Plan Home and Community-Based Services benefit and the home  
13 and community-based services waiver program authorized under  
14 Section 1915(c) of the Social Security Act for persons who are  
15 medically fragile and technology dependent. To be eligible for  
16 reimbursement under this Section, a legally responsible family  
17 caregiver must be a certified nursing assistant or certified  
18 nurse aide and must provide services to a medically fragile  
19 relative who is receiving in-home shift nursing services  
20 coordinated by the University of Illinois at Chicago, Division  
21 of Specialized Care for Children. Upon federal approval of the  
22 State Plan amendment and waiver, the Department shall  
23 promulgate rules that define who qualifies for reimbursement  
24 as a legally responsible family caregiver, specify which

1 personal care and home health aide services are eligible for  
2 reimbursement if the provider is a legally responsible family  
3 caregiver, establish oversight policies to ensure legally  
4 responsible family caregivers meet and comply with licensing  
5 and program requirements, and adopt any other policies or  
6 procedures necessary to implement this Section.

7 ARTICLE 175.

8 Section 175-5. The Illinois Public Aid Code is amended by  
9 changing Section 5-5.5 as follows:

10 (305 ILCS 5/5-5.5) (from Ch. 23, par. 5-5.5)

11 Sec. 5-5.5. Elements of Payment Rate.

12 (a) The Department of Healthcare and Family Services shall  
13 develop a prospective method for determining payment rates for  
14 nursing facility and ICF/DD services in nursing facilities  
15 composed of the following cost elements:

16 (1) Standard Services, with the cost of this component  
17 being determined by taking into account the actual costs  
18 to the facilities of these services subject to cost  
19 ceilings to be defined in the Department's rules.

20 (2) Resident Services, with the cost of this component  
21 being determined by taking into account the actual costs,  
22 needs and utilization of these services, as derived from  
23 an assessment of the resident needs in the nursing

1 facilities.

2 (3) Ancillary Services, with the payment rate being  
3 developed for each individual type of service. Payment  
4 shall be made only when authorized under procedures  
5 developed by the Department of Healthcare and Family  
6 Services.

7 (4) Nurse's Aide Training, with the cost of this  
8 component being determined by taking into account the  
9 actual cost to the facilities of such training.

10 (5) Real Estate Taxes, with the cost of this component  
11 being determined by taking into account the figures  
12 contained in the most currently available cost reports  
13 (with no imposition of maximums) updated to the midpoint  
14 of the current rate year for long term care services  
15 rendered between July 1, 1984 and June 30, 1985, and with  
16 the cost of this component being determined by taking into  
17 account the actual 1983 taxes for which the nursing homes  
18 were assessed (with no imposition of maximums) updated to  
19 the midpoint of the current rate year for long term care  
20 services rendered between July 1, 1985 and June 30, 1986.

21 (b) In developing a prospective method for determining  
22 payment rates for nursing facility and ICF/DD services in  
23 nursing facilities and ICF/DDs, the Department of Healthcare  
24 and Family Services shall consider the following cost  
25 elements:

26 (1) Reasonable capital cost determined by utilizing

1 incurred interest rate and the current value of the  
2 investment, including land, utilizing composite rates, or  
3 by utilizing such other reasonable cost related methods  
4 determined by the Department. However, beginning with the  
5 rate reimbursement period effective July 1, 1987, the  
6 Department shall be prohibited from establishing,  
7 including, and implementing any depreciation factor in  
8 calculating the capital cost element.

9 (2) Profit, with the actual amount being produced and  
10 accruing to the providers in the form of a return on their  
11 total investment, on the basis of their ability to  
12 economically and efficiently deliver a type of service.  
13 The method of payment may assure the opportunity for a  
14 profit, but shall not guarantee or establish a specific  
15 amount as a cost.

16 (c) The Illinois Department may implement the amendatory  
17 changes to this Section made by this amendatory Act of 1991  
18 through the use of emergency rules in accordance with the  
19 provisions of Section 5.02 of the Illinois Administrative  
20 Procedure Act. For purposes of the Illinois Administrative  
21 Procedure Act, the adoption of rules to implement the  
22 amendatory changes to this Section made by this amendatory Act  
23 of 1991 shall be deemed an emergency and necessary for the  
24 public interest, safety and welfare.

25 (d) No later than January 1, 2001, the Department of  
26 Public Aid shall file with the Joint Committee on

1 Administrative Rules, pursuant to the Illinois Administrative  
2 Procedure Act, a proposed rule, or a proposed amendment to an  
3 existing rule, regarding payment for appropriate services,  
4 including assessment, care planning, discharge planning, and  
5 treatment provided by nursing facilities to residents who have  
6 a serious mental illness.

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

12 (f) Beginning January 1, 2025, the real estate tax  
13 component of the payment rate shall be updated using the most  
14 recent property tax bill on file with the Department for  
15 facilities licensed under the Nursing Home Care Act and  
16 facilities licensed under the Specialized Mental Health  
17 Rehabilitation Act of 2013. The per diem rate shall be  
18 computed by dividing the real estate tax costs reported in the  
19 cost report inflated to the midpoint of the rate year by the  
20 total number of patient days reported in the same cost report.  
21 Computation of the real estate tax component shall be based on  
22 capital days.

23 (Source: P.A. 96-1123, eff. 1-1-11; 96-1530, eff. 2-16-11;  
24 97-689, eff. 6-14-12.)

1 Section 180-5. The Illinois Public Aid Code is amended by  
2 changing Section 5-5.2 as follows:

3 (305 ILCS 5/5-5.2)

4 Sec. 5-5.2. Payment.

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

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

11 (c) (Blank).

12 (c-1) Notwithstanding any other provisions of this Code,  
13 the methodologies for reimbursement of nursing services as  
14 provided under this Article shall no longer be applicable for  
15 bills payable for nursing services rendered on or after a new  
16 reimbursement system based on the Patient Driven Payment Model  
17 (PDPM) has been fully operationalized, which shall take effect  
18 for services provided on or after the implementation of the  
19 PDPM reimbursement system begins. For the purposes of Public  
20 Act 102-1035 ~~this amendatory Act of the 102nd General~~  
21 ~~Assembly~~, the implementation date of the PDPM reimbursement  
22 system and all related provisions shall be July 1, 2022 if the  
23 following conditions are met: (i) the Centers for Medicare and  
24 Medicaid Services has approved corresponding changes in the



1 reimbursement system and bed assessment; and (ii) the  
2 Department has filed rules to implement these changes no later  
3 than June 1, 2022. Failure of the Department to file rules to  
4 implement the changes provided in Public Act 102-1035 ~~this~~  
5 ~~amendatory Act of the 102nd General Assembly~~ no later than  
6 June 1, 2022 shall result in the implementation date being  
7 delayed to October 1, 2022.

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

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

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

25 (3) Regional wage adjustors based on the Health  
26 Service Areas (HSA) groupings and adjusters in effect on

1 April 30, 2012 shall be included, except no adjuster shall  
2 be lower than 1.06.

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

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

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

23 Beginning October 1, 2024, the staffing percentage  
24 used in the calculation of the per diem staffing add-on  
25 shall be its PDPM STRIVE Staffing Ratio which equals: its  
26 Reported Total Nurse Staffing Hours Per Resident Per Day

1 as published in the most recent federal staffing report  
2 (the Provider Information File), divided by the facility's  
3 PDPM STRIVE Staffing Target. Each facility's PDPM STRIVE  
4 Staffing Target is equal to .82 times the facility's  
5 Illinois Adjusted Facility Case-Mix Hours Per Resident Per  
6 Day. A facility's Illinois Adjusted Facility Case Mix  
7 Hours Per Resident Per Day is equal to its Case-Mix Total  
8 Nurse Staffing Hours Per Resident Per Day (as published in  
9 the most recent federal staffing report) times 3.662  
10 (which reflects the national resident days-weighted mean  
11 Reported Total Nurse Staffing Hours Per Resident Per Day  
12 as calculated using the January 2024 federal Provider  
13 Information Files), divided by the national resident  
14 days-weighted mean Reported Total Nurse Staffing Hours Per  
15 Resident Per Day calculated using the most recent federal  
16 Provider Information File.

17 (6.5) Beginning July 1, 2024, the paid per diem  
18 staffing add-on shall be the paid per diem staffing add-on  
19 in effect April 1, 2024. For dates beginning October 1,  
20 2024 and through September 30, 2025, the denominator for  
21 the staffing percentage shall be the lesser of the  
22 facility's PDPM STRIVE Staffing Target and:

23 (A) For the quarter beginning October 1, 2024, the  
24 sum of 20% of the facility's PDPM STRIVE Staffing  
25 Target and 80% of the facility's Case-Mix Total Nurse  
26 Staffing Hours Per Resident Per Day (as published in

1 the January 2024 federal staffing report).

2 (B) For the quarter beginning January 1, 2025, the  
3 sum of 40% of the facility's PDPM STRIVE Staffing  
4 Target and 60% of the facility's Case-Mix Total Nurse  
5 Staffing Hours Per Resident Per Day (as published in  
6 the January 2024 federal staffing report).

7 (C) For the quarter beginning March 1, 2025, the  
8 sum of 60% of the facility's PDPM STRIVE Staffing  
9 Target and 40% of the facility's Case-Mix Total Nurse  
10 Staffing Hours Per Resident Per Day (as published in  
11 the January 2024 federal staffing report).

12 (D) For the quarter beginning July 1, 2025, the  
13 sum of 80% of the facility's PDPM STRIVE Staffing  
14 Target and 20% of the facility's Case-Mix Total Nurse  
15 Staffing Hours Per Resident Per Day (as published in  
16 the January 2024 federal staffing report).

17 Facilities with at least 70% of the staffing  
18 indicated by the STRIVE study shall be paid a per diem  
19 add-on of \$9, increasing by equivalent steps for each  
20 whole percentage point until the facilities reach a per  
21 diem of \$16.52 ~~\$14.88~~. Facilities with at least 80% of the  
22 staffing indicated by the STRIVE study shall be paid a per  
23 diem add-on of \$16.52 ~~\$14.88~~, increasing by equivalent  
24 steps for each whole percentage point until the facilities  
25 reach a per diem add-on of \$25.77 ~~\$23.80~~. Facilities with  
26 at least 92% of the staffing indicated by the STRIVE study

1 shall be paid a per diem add-on of \$25.77 ~~\$23.80~~,  
2 increasing by equivalent steps for each whole percentage  
3 point until the facilities reach a per diem add-on of  
4 \$30.98 ~~\$29.75~~. Facilities with at least 100% of the  
5 staffing indicated by the STRIVE study shall be paid a per  
6 diem add-on of \$30.98 ~~\$29.75~~, increasing by equivalent  
7 steps for each whole percentage point until the facilities  
8 reach a per diem add-on of \$36.44 ~~\$35.70~~. Facilities with  
9 at least 110% of the staffing indicated by the STRIVE  
10 study shall be paid a per diem add-on of \$36.44 ~~\$35.70~~,  
11 increasing by equivalent steps for each whole percentage  
12 point until the facilities reach a per diem add-on of  
13 \$38.68. Facilities with at least 125% or higher of the  
14 staffing indicated by the STRIVE study shall be paid a per  
15 diem add-on of \$38.68. ~~No Beginning April 1, 2023, no~~  
16 nursing facility's variable staffing per diem add-on shall  
17 be reduced by more than 5% in 2 consecutive quarters. For  
18 the quarters beginning July 1, 2022 and October 1, 2022,  
19 no facility's variable per diem staffing add-on shall be  
20 calculated at a rate lower than 85% of the staffing  
21 indicated by the STRIVE study. No facility below 70% of  
22 the staffing indicated by the STRIVE study shall receive a  
23 variable per diem staffing add-on after December 31, 2022.

24 (7) For dates of services beginning July 1, 2022, the  
25 PDPM nursing component per diem for each nursing facility  
26 shall be the product of the facility's (i) statewide PDPM

1 nursing base per diem rate, \$92.25, adjusted for the  
2 facility average PDPM case mix index calculated quarterly  
3 and (ii) the regional wage adjuster, and then add the  
4 Medicaid access adjustment as defined in (e-3) of this  
5 Section. Transition rates for services provided between  
6 July 1, 2022 and October 1, 2023 shall be the greater of  
7 the PDPM nursing component per diem or:

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

10 (B) for the quarter beginning October 1, 2022, the  
11 sum of the RUG-IV nursing component per diem  
12 multiplied by 0.80 and the PDPM nursing component per  
13 diem multiplied by 0.20;

14 (C) for the quarter beginning January 1, 2023, the  
15 sum of the RUG-IV nursing component per diem  
16 multiplied by 0.60 and the PDPM nursing component per  
17 diem multiplied by 0.40;

18 (D) for the quarter beginning April 1, 2023, the  
19 sum of the RUG-IV nursing component per diem  
20 multiplied by 0.40 and the PDPM nursing component per  
21 diem multiplied by 0.60;

22 (E) for the quarter beginning July 1, 2023, the  
23 sum of the RUG-IV nursing component per diem  
24 multiplied by 0.20 and the PDPM nursing component per  
25 diem multiplied by 0.80; or

26 (F) for the quarter beginning October 1, 2023 and

1           each subsequent quarter, the transition rate shall end  
2           and a nursing facility shall be paid 100% of the PDPM  
3           nursing component per diem.

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

6           (1) Base rate spending pool shall be:

7           (A) The base year resident days which are  
8           calculated by multiplying the number of Medicaid  
9           residents in each nursing home as indicated in the MDS  
10          data defined in paragraph (4) by 365.

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

14          (C) Thirteen million is added to the product of  
15          subparagraph (A) and subparagraph (B) to adjust for  
16          the exclusion of nursing homes defined in paragraph  
17          (5).

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

23                (A) Base year resident days as calculated in  
24                subparagraph (A) of paragraph (1).

25                (B) The nursing home's regional wage adjustor  
26                based on the Health Service Areas (HSA) groupings and

1 adjustors in effect on April 30, 2012.

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

7 (D) The sum of the products calculated for each  
8 nursing home in subparagraphs (A) through (C) above  
9 shall be the base year case mix, rate adjusted  
10 weighted days.

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

12 (A) on January 1, 2014 shall be the quotient of the  
13 paragraph (1) divided by the sum calculated under  
14 subparagraph (D) of paragraph (2);

15 (B) on and after July 1, 2014 and until July 1,  
16 2022, shall be the amount calculated under  
17 subparagraph (A) of this paragraph (3) plus \$1.76; and

18 (C) beginning July 1, 2022 and thereafter, \$7  
19 shall be added to the amount calculated under  
20 subparagraph (B) of this paragraph (3) of this  
21 Section.

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

25 (5) Nursing facilities designated as of July 1, 2012  
26 by the Department as "Institutions for Mental Disease"



1 shall be excluded from all calculations under this  
2 subsection. The data from these facilities shall not be  
3 used in the computations described in paragraphs (1)  
4 through (4) above to establish the base rate.

5 (e) Beginning July 1, 2014, the Department shall allocate  
6 funding in the amount up to \$10,000,000 for per diem add-ons to  
7 the RUGS methodology for dates of service on and after July 1,  
8 2014:

9 (1) \$0.63 for each resident who scores in I4200  
10 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

11 (2) \$2.67 for each resident who scores either a "1" or  
12 "2" in any items S1200A through S1200I and also scores in  
13 RUG groups PA1, PA2, BA1, or BA2.

14 (e-1) (Blank).

15 (e-2) For dates of services beginning January 1, 2014 and  
16 ending September 30, 2023, the RUG-IV nursing component per  
17 diem for a nursing home shall be the product of the statewide  
18 RUG-IV nursing base per diem rate, the facility average case  
19 mix index, and the regional wage adjustor. For dates of  
20 service beginning July 1, 2022 and ending September 30, 2023,  
21 the Medicaid access adjustment described in subsection (e-3)  
22 shall be added to the product.

23 (e-3) A Medicaid Access Adjustment of \$4 adjusted for the  
24 facility average PDPM case mix index calculated quarterly  
25 shall be added to the statewide PDPM nursing per diem for all  
26 facilities with annual Medicaid bed days of at least 70% of all

1 occupied bed days adjusted quarterly. For each new calendar  
2 year and for the 6-month period beginning July 1, 2022, the  
3 percentage of a facility's occupied bed days comprised of  
4 Medicaid bed days shall be determined by the Department  
5 quarterly. For dates of service beginning January 1, 2023, the  
6 Medicaid Access Adjustment shall be increased to \$4.75. This  
7 subsection shall be inoperative on and after January 1, 2028.

8 (e-4) Subject to federal approval, on and after January 1,  
9 2024, the Department shall increase the rate add-on at  
10 paragraph (7) subsection (a) under 89 Ill. Adm. Code 147.335  
11 for ventilator services from \$208 per day to \$481 per day.  
12 Payment is subject to the criteria and requirements under 89  
13 Ill. Adm. Code 147.335.

14 (f) (Blank).

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

20 (1) (Blank);

21 (2) (Blank);

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

24 (h) Notwithstanding any other provision of this Code, on  
25 and after July 1, 2012, nursing facilities designated by the  
26 Department of Healthcare and Family Services as "Institutions

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

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

12 (i-1) Subject to federal approval, on and after January 1,  
13 2024, the reimbursement rates for the support component of the  
14 nursing facility rate for facilities licensed under the  
15 Nursing Home Care Act as skilled or intermediate care  
16 facilities shall be the rate in effect on June 30, 2023  
17 increased by 12%.

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

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

12 (1) 80%, or \$136,000,000, of the funds shall be used  
13 to update each facility's rate in effect on June 30, 2019  
14 using the most recent cost reports on file, which have had  
15 a limited review conducted by the Department of Healthcare  
16 and Family Services and will not hold up enacting the rate  
17 increase, with the Department of Healthcare and Family  
18 Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 payors. The Department may establish, by rule, changes  
2 to the methodology for distributing quality pool  
3 payments.

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

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

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



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

23 (m) The Department shall work with nursing facility  
24 industry representatives to design policies and procedures to  
25 permit facilities to address the integrity of data from  
26 federal reporting sites used by the Department in setting

1 facility rates.

2 (Source: P.A. 102-77, eff. 7-9-21; 102-558, eff. 8-20-21;  
3 102-1035, eff. 5-31-22; 102-1118, eff. 1-18-23; 103-102,  
4 Article 40, Section 40-5, eff. 1-1-24; 103-102, Article 50,  
5 Section 50-5, eff. 1-1-24; revised 12-15-23.)

6 ARTICLE 185.

7 Section 185-5. The Illinois Public Aid Code is amended by  
8 changing Section 5-5a.1 as follows:

9 (305 ILCS 5/5-5a.1)

10 Sec. 5-5a.1. Telehealth services for persons with  
11 intellectual and developmental disabilities. The Department  
12 shall file an amendment to the Home and Community-Based  
13 Services Waiver Program for Adults with Developmental  
14 Disabilities authorized under Section 1915(c) of the Social  
15 Security Act to incorporate telehealth services administered  
16 by a provider of telehealth services that demonstrates  
17 knowledge and experience in providing medical and emergency  
18 services for persons with intellectual and developmental  
19 disabilities. For dates of service on and after January 1,  
20 2025, the Department shall pay negotiated, agreed upon  
21 administrative fees associated with implementing telehealth  
22 services for persons with intellectual and developmental  
23 disabilities who are receiving Community Integrated Living

1 Arrangement residential services under the Home and  
2 Community-Based Services Waiver Program for Adults with  
3 Developmental Disabilities. The implementation of telehealth  
4 services shall not impede the choice of any individual  
5 receiving waiver-funded services through the Home and  
6 Community-Based Services Waiver Program for Adults with  
7 Developmental Disabilities to receive in-person health care  
8 services at any time. The Department shall ensure individuals  
9 enrolled in the waiver, or their guardians, request to opt-in  
10 to these services. For individuals who opt in, this service  
11 shall be included in the individual's person-centered plan.  
12 The use of telehealth services shall not be used for the  
13 convenience of staff at any time nor shall it replace primary  
14 care physician services. ~~The Department shall pay~~  
15 ~~administrative fees associated with implementing telehealth~~  
16 ~~services for all persons with intellectual and developmental~~  
17 ~~disabilities who are receiving services under the Home and~~  
18 ~~Community Based Services Waiver Program for Adults with~~  
19 ~~Developmental Disabilities.~~

20 (Source: P.A. 103-102, eff. 7-1-23.)

21 ARTICLE 190.

22 Section 190-5. The Pharmacy Practice Act is amended by  
23 changing Sections 3 and 9.6 as follows:

1 (225 ILCS 85/3)

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

3 Sec. 3. Definitions. For the purpose of this Act, except  
4 where otherwise limited therein:

5 (a) "Pharmacy" or "drugstore" means and includes every  
6 store, shop, pharmacy department, or other place where  
7 pharmacist care is provided by a pharmacist (1) where drugs,  
8 medicines, or poisons are dispensed, sold or offered for sale  
9 at retail, or displayed for sale at retail; or (2) where  
10 prescriptions of physicians, dentists, advanced practice  
11 registered nurses, physician assistants, veterinarians,  
12 podiatric physicians, or optometrists, within the limits of  
13 their licenses, are compounded, filled, or dispensed; or (3)  
14 which has upon it or displayed within it, or affixed to or used  
15 in connection with it, a sign bearing the word or words  
16 "Pharmacist", "Druggist", "Pharmacy", "Pharmaceutical Care",  
17 "Apothecary", "Drugstore", "Medicine Store", "Prescriptions",  
18 "Drugs", "Dispensary", "Medicines", or any word or words of  
19 similar or like import, either in the English language or any  
20 other language; or (4) where the characteristic prescription  
21 sign (Rx) or similar design is exhibited; or (5) any store, or  
22 shop, or other place with respect to which any of the above  
23 words, objects, signs or designs are used in any  
24 advertisement.

25 (b) "Drugs" means and includes (1) articles recognized in  
26 the official United States Pharmacopoeia/National Formulary

1 (USP/NF), or any supplement thereto and being intended for and  
2 having for their main use the diagnosis, cure, mitigation,  
3 treatment or prevention of disease in man or other animals, as  
4 approved by the United States Food and Drug Administration,  
5 but does not include devices or their components, parts, or  
6 accessories; and (2) all other articles intended for and  
7 having for their main use the diagnosis, cure, mitigation,  
8 treatment or prevention of disease in man or other animals, as  
9 approved by the United States Food and Drug Administration,  
10 but does not include devices or their components, parts, or  
11 accessories; and (3) articles (other than food) having for  
12 their main use and intended to affect the structure or any  
13 function of the body of man or other animals; and (4) articles  
14 having for their main use and intended for use as a component  
15 or any articles specified in clause (1), (2) or (3); but does  
16 not include devices or their components, parts or accessories.

17 (c) "Medicines" means and includes all drugs intended for  
18 human or veterinary use approved by the United States Food and  
19 Drug Administration.

20 (d) "Practice of pharmacy" means:

21 (1) the interpretation and the provision of assistance  
22 in the monitoring, evaluation, and implementation of  
23 prescription drug orders;

24 (2) the dispensing of prescription drug orders;

25 (3) participation in drug and device selection;

26 (4) drug administration limited to the administration

1 of oral, topical, injectable, and inhalation as follows:

2 (A) in the context of patient education on the  
3 proper use or delivery of medications;

4 (B) vaccination of patients 7 years of age and  
5 older pursuant to a valid prescription or standing  
6 order, by a physician licensed to practice medicine in  
7 all its branches, except for vaccinations covered by  
8 paragraph (15), upon completion of appropriate  
9 training, including how to address contraindications  
10 and adverse reactions set forth by rule, with  
11 notification to the patient's physician and  
12 appropriate record retention, or pursuant to hospital  
13 pharmacy and therapeutics committee policies and  
14 procedures. Eligible vaccines are those listed on the  
15 U.S. Centers for Disease Control and Prevention (CDC)  
16 Recommended Immunization Schedule, the CDC's Health  
17 Information for International Travel, or the U.S. Food  
18 and Drug Administration's Vaccines Licensed and  
19 Authorized for Use in the United States. As applicable  
20 to the State's Medicaid program and other payers,  
21 vaccines ordered and administered in accordance with  
22 this subsection shall be covered and reimbursed at no  
23 less than the rate that the vaccine is reimbursed when  
24 ordered and administered by a physician;

25 (B-5) following the initial administration of  
26 long-acting or extended-release form opioid

1           antagonists by a physician licensed to practice  
2           medicine in all its branches, administration of  
3           injections of long-acting or extended-release form  
4           opioid antagonists for the treatment of substance use  
5           disorder, pursuant to a valid prescription by a  
6           physician licensed to practice medicine in all its  
7           branches, upon completion of appropriate training,  
8           including how to address contraindications and adverse  
9           reactions, including, but not limited to, respiratory  
10          depression and the performance of cardiopulmonary  
11          resuscitation, set forth by rule, with notification to  
12          the patient's physician and appropriate record  
13          retention, or pursuant to hospital pharmacy and  
14          therapeutics committee policies and procedures;

15               (C)       administration       of       injections       of  
16           alpha-hydroxyprogesterone caproate, pursuant to a  
17           valid prescription, by a physician licensed to  
18           practice medicine in all its branches, upon completion  
19           of appropriate training, including how to address  
20           contraindications and adverse reactions set forth by  
21           rule, with notification to the patient's physician and  
22           appropriate record retention, or pursuant to hospital  
23           pharmacy and therapeutics committee policies and  
24           procedures; and

25               (D)       administration       of       injections       of       long-term  
26           antipsychotic medications pursuant to a valid

1 prescription by a physician licensed to practice  
2 medicine in all its branches, upon completion of  
3 appropriate training conducted by an Accreditation  
4 Council of Pharmaceutical Education accredited  
5 provider, including how to address contraindications  
6 and adverse reactions set forth by rule, with  
7 notification to the patient's physician and  
8 appropriate record retention, or pursuant to hospital  
9 pharmacy and therapeutics committee policies and  
10 procedures.

11 (5) (blank);

12 (6) drug regimen review;

13 (7) drug or drug-related research;

14 (8) the provision of patient counseling;

15 (9) the practice of telepharmacy;

16 (10) the provision of those acts or services necessary  
17 to provide pharmacist care;

18 (11) medication therapy management;

19 (12) the responsibility for compounding and labeling  
20 of drugs and devices (except labeling by a manufacturer,  
21 repackager, or distributor of non-prescription drugs and  
22 commercially packaged legend drugs and devices), proper  
23 and safe storage of drugs and devices, and maintenance of  
24 required records;

25 (13) the assessment and consultation of patients and  
26 dispensing of hormonal contraceptives;



1           (14) the initiation, dispensing, or administration of  
2           drugs, laboratory tests, assessments, referrals, and  
3           consultations for human immunodeficiency virus  
4           pre-exposure prophylaxis and human immunodeficiency virus  
5           post-exposure prophylaxis under Section 43.5;

6           (15) vaccination of patients 7 years of age and older  
7           for COVID-19 or influenza subcutaneously, intramuscularly,  
8           or orally as authorized, approved, or licensed by the  
9           United States Food and Drug Administration, pursuant to  
10          the following conditions:

11                   (A) the vaccine must be authorized or licensed by  
12                   the United States Food and Drug Administration;

13                   (B) the vaccine must be ordered and administered  
14                   according to the Advisory Committee on Immunization  
15                   Practices standard immunization schedule;

16                   (C) the pharmacist must complete a course of  
17                   training accredited by the Accreditation Council on  
18                   Pharmacy Education or a similar health authority or  
19                   professional body approved by the Division of  
20                   Professional Regulation;

21                   (D) the pharmacist must have a current certificate  
22                   in basic cardiopulmonary resuscitation;

23                   (E) the pharmacist must complete, during each  
24                   State licensing period, a minimum of 2 hours of  
25                   immunization-related continuing pharmacy education  
26                   approved by the Accreditation Council on Pharmacy

1 Education;

2 (F) the pharmacist must comply with recordkeeping  
3 and reporting requirements of the jurisdiction in  
4 which the pharmacist administers vaccines, including  
5 informing the patient's primary-care provider, when  
6 available, and complying with requirements whereby the  
7 person administering a vaccine must review the vaccine  
8 registry or other vaccination records prior to  
9 administering the vaccine; and

10 (G) the pharmacist must inform the pharmacist's  
11 patients who are less than 18 years old, as well as the  
12 adult caregiver accompanying the child, of the  
13 importance of a well-child visit with a pediatrician  
14 or other licensed primary-care provider and must refer  
15 patients as appropriate;

16 (16) the ordering and administration of COVID-19  
17 therapeutics subcutaneously, intramuscularly, or orally  
18 with notification to the patient's physician and  
19 appropriate record retention or pursuant to hospital  
20 pharmacy and therapeutics committee policies and  
21 procedures. Eligible therapeutics are those approved,  
22 authorized, or licensed by the United States Food and Drug  
23 Administration and must be administered subcutaneously,  
24 intramuscularly, or orally in accordance with that  
25 approval, authorization, or licensing; and

26 (17) the ordering and administration of point of care

1 tests, ~~and~~ screenings, and treatments for (i) influenza,  
2 (ii) SARS-CoV-2 ~~SARS-COV-2~~, (iii) Group A Streptococcus,  
3 (iv) respiratory syncytial virus, (v) adult-stage head  
4 louse, and (vi) ~~(iii)~~ health conditions identified by a  
5 statewide public health emergency, as defined in the  
6 Illinois Emergency Management Agency Act, with  
7 notification to the patient's physician, if any, and  
8 appropriate record retention or pursuant to hospital  
9 pharmacy and therapeutics committee policies and  
10 procedures. Eligible tests and screenings are those  
11 approved, authorized, or licensed by the United States  
12 Food and Drug Administration and must be administered in  
13 accordance with that approval, authorization, or  
14 licensing.

15 A pharmacist who orders or administers tests or  
16 screenings for health conditions described in this  
17 paragraph may use a test that may guide clinical  
18 decision-making for the health condition that is waived  
19 under the federal Clinical Laboratory Improvement  
20 Amendments of 1988 and regulations promulgated thereunder  
21 or any established screening procedure that is established  
22 under a statewide protocol.

23 A pharmacist may delegate the administrative and  
24 technical tasks of performing a test for the health  
25 conditions described in this paragraph to a registered  
26 pharmacy technician or student pharmacist acting under the

1 supervision of the pharmacist.

2 The testing, screening, and treatment ordered under  
3 this paragraph by a pharmacist shall not be denied  
4 reimbursement under health benefit plans that are within  
5 the scope of the pharmacist's license and shall be covered  
6 as if the services or procedures were performed by a  
7 physician, an advanced practice registered nurse, or a  
8 physician assistant.

9 A pharmacy benefit manager, health carrier, health  
10 benefit plan, or third-party payor shall not discriminate  
11 against a pharmacy or a pharmacist with respect to  
12 participation referral, reimbursement of a covered  
13 service, or indemnification if a pharmacist is acting  
14 within the scope of the pharmacist's license and the  
15 pharmacy is operating in compliance with all applicable  
16 laws and rules.

17 A pharmacist who performs any of the acts defined as the  
18 practice of pharmacy in this State must be actively licensed  
19 as a pharmacist under this Act.

20 (e) "Prescription" means and includes any written, oral,  
21 facsimile, or electronically transmitted order for drugs or  
22 medical devices, issued by a physician licensed to practice  
23 medicine in all its branches, dentist, veterinarian, podiatric  
24 physician, or optometrist, within the limits of his or her  
25 license, by a physician assistant in accordance with  
26 subsection (f) of Section 4, or by an advanced practice

1 registered nurse in accordance with subsection (g) of Section  
2 4, containing the following: (1) name of the patient; (2) date  
3 when prescription was issued; (3) name and strength of drug or  
4 description of the medical device prescribed; and (4)  
5 quantity; (5) directions for use; (6) prescriber's name,  
6 address, and signature; and (7) DEA registration number where  
7 required, for controlled substances. The prescription may, but  
8 is not required to, list the illness, disease, or condition  
9 for which the drug or device is being prescribed. DEA  
10 registration numbers shall not be required on inpatient drug  
11 orders. A prescription for medication other than controlled  
12 substances shall be valid for up to 15 months from the date  
13 issued for the purpose of refills, unless the prescription  
14 states otherwise.

15 (f) "Person" means and includes a natural person,  
16 partnership, association, corporation, government entity, or  
17 any other legal entity.

18 (g) "Department" means the Department of Financial and  
19 Professional Regulation.

20 (h) "Board of Pharmacy" or "Board" means the State Board  
21 of Pharmacy of the Department of Financial and Professional  
22 Regulation.

23 (i) "Secretary" means the Secretary of Financial and  
24 Professional Regulation.

25 (j) "Drug product selection" means the interchange for a  
26 prescribed pharmaceutical product in accordance with Section

1 25 of this Act and Section 3.14 of the Illinois Food, Drug and  
2 Cosmetic Act.

3 (k) "Inpatient drug order" means an order issued by an  
4 authorized prescriber for a resident or patient of a facility  
5 licensed under the Nursing Home Care Act, the ID/DD Community  
6 Care Act, the MC/DD Act, the Specialized Mental Health  
7 Rehabilitation Act of 2013, the Hospital Licensing Act, or the  
8 University of Illinois Hospital Act, or a facility which is  
9 operated by the Department of Human Services (as successor to  
10 the Department of Mental Health and Developmental  
11 Disabilities) or the Department of Corrections.

12 (k-5) "Pharmacist" means an individual health care  
13 professional and provider currently licensed by this State to  
14 engage in the practice of pharmacy.

15 (l) "Pharmacist in charge" means the licensed pharmacist  
16 whose name appears on a pharmacy license and who is  
17 responsible for all aspects of the operation related to the  
18 practice of pharmacy.

19 (m) "Dispense" or "dispensing" means the interpretation,  
20 evaluation, and implementation of a prescription drug order,  
21 including the preparation and delivery of a drug or device to a  
22 patient or patient's agent in a suitable container  
23 appropriately labeled for subsequent administration to or use  
24 by a patient in accordance with applicable State and federal  
25 laws and regulations. "Dispense" or "dispensing" does not mean  
26 the physical delivery to a patient or a patient's

1 representative in a home or institution by a designee of a  
2 pharmacist or by common carrier. "Dispense" or "dispensing"  
3 also does not mean the physical delivery of a drug or medical  
4 device to a patient or patient's representative by a  
5 pharmacist's designee within a pharmacy or drugstore while the  
6 pharmacist is on duty and the pharmacy is open.

7 (n) "Nonresident pharmacy" means a pharmacy that is  
8 located in a state, commonwealth, or territory of the United  
9 States, other than Illinois, that delivers, dispenses, or  
10 distributes, through the United States Postal Service,  
11 commercially acceptable parcel delivery service, or other  
12 common carrier, to Illinois residents, any substance which  
13 requires a prescription.

14 (o) "Compounding" means the preparation and mixing of  
15 components, excluding flavorings, (1) as the result of a  
16 prescriber's prescription drug order or initiative based on  
17 the prescriber-patient-pharmacist relationship in the course  
18 of professional practice or (2) for the purpose of, or  
19 incident to, research, teaching, or chemical analysis and not  
20 for sale or dispensing. "Compounding" includes the preparation  
21 of drugs or devices in anticipation of receiving prescription  
22 drug orders based on routine, regularly observed dispensing  
23 patterns. Commercially available products may be compounded  
24 for dispensing to individual patients only if all of the  
25 following conditions are met: (i) the commercial product is  
26 not reasonably available from normal distribution channels in

1 a timely manner to meet the patient's needs and (ii) the  
2 prescribing practitioner has requested that the drug be  
3 compounded.

4 (p) (Blank).

5 (q) (Blank).

6 (r) "Patient counseling" means the communication between a  
7 pharmacist or a student pharmacist under the supervision of a  
8 pharmacist and a patient or the patient's representative about  
9 the patient's medication or device for the purpose of  
10 optimizing proper use of prescription medications or devices.  
11 "Patient counseling" may include without limitation (1)  
12 obtaining a medication history; (2) acquiring a patient's  
13 allergies and health conditions; (3) facilitation of the  
14 patient's understanding of the intended use of the medication;  
15 (4) proper directions for use; (5) significant potential  
16 adverse events; (6) potential food-drug interactions; and (7)  
17 the need to be compliant with the medication therapy. A  
18 pharmacy technician may only participate in the following  
19 aspects of patient counseling under the supervision of a  
20 pharmacist: (1) obtaining medication history; (2) providing  
21 the offer for counseling by a pharmacist or student  
22 pharmacist; and (3) acquiring a patient's allergies and health  
23 conditions.

24 (s) "Patient profiles" or "patient drug therapy record"  
25 means the obtaining, recording, and maintenance of patient  
26 prescription information, including prescriptions for



1 controlled substances, and personal information.

2 (t) (Blank).

3 (u) "Medical device" or "device" means an instrument,  
4 apparatus, implement, machine, contrivance, implant, in vitro  
5 reagent, or other similar or related article, including any  
6 component part or accessory, required under federal law to  
7 bear the label "Caution: Federal law requires dispensing by or  
8 on the order of a physician". A seller of goods and services  
9 who, only for the purpose of retail sales, compounds, sells,  
10 rents, or leases medical devices shall not, by reasons  
11 thereof, be required to be a licensed pharmacy.

12 (v) "Unique identifier" means an electronic signature,  
13 handwritten signature or initials, thumb print, or other  
14 acceptable biometric or electronic identification process as  
15 approved by the Department.

16 (w) "Current usual and customary retail price" means the  
17 price that a pharmacy charges to a non-third-party payor.

18 (x) "Automated pharmacy system" means a mechanical system  
19 located within the confines of the pharmacy or remote location  
20 that performs operations or activities, other than compounding  
21 or administration, relative to storage, packaging, dispensing,  
22 or distribution of medication, and which collects, controls,  
23 and maintains all transaction information.

24 (y) "Drug regimen review" means and includes the  
25 evaluation of prescription drug orders and patient records for  
26 (1) known allergies; (2) drug or potential therapy

1     contraindications; (3) reasonable dose, duration of use, and  
2     route of administration, taking into consideration factors  
3     such as age, gender, and contraindications; (4) reasonable  
4     directions for use; (5) potential or actual adverse drug  
5     reactions; (6) drug-drug interactions; (7) drug-food  
6     interactions; (8) drug-disease contraindications; (9)  
7     therapeutic duplication; (10) patient laboratory values when  
8     authorized and available; (11) proper utilization (including  
9     over or under utilization) and optimum therapeutic outcomes;  
10    and (12) abuse and misuse.

11         (z) "Electronically transmitted prescription" means a  
12     prescription that is created, recorded, or stored by  
13     electronic means; issued and validated with an electronic  
14     signature; and transmitted by electronic means directly from  
15     the prescriber to a pharmacy. An electronic prescription is  
16     not an image of a physical prescription that is transferred by  
17     electronic means from computer to computer, facsimile to  
18     facsimile, or facsimile to computer.

19         (aa) "Medication therapy management services" means a  
20     distinct service or group of services offered by licensed  
21     pharmacists, physicians licensed to practice medicine in all  
22     its branches, advanced practice registered nurses authorized  
23     in a written agreement with a physician licensed to practice  
24     medicine in all its branches, or physician assistants  
25     authorized in guidelines by a supervising physician that  
26     optimize therapeutic outcomes for individual patients through

1 improved medication use. In a retail or other non-hospital  
2 pharmacy, medication therapy management services shall consist  
3 of the evaluation of prescription drug orders and patient  
4 medication records to resolve conflicts with the following:

5 (1) known allergies;

6 (2) drug or potential therapy contraindications;

7 (3) reasonable dose, duration of use, and route of  
8 administration, taking into consideration factors such as  
9 age, gender, and contraindications;

10 (4) reasonable directions for use;

11 (5) potential or actual adverse drug reactions;

12 (6) drug-drug interactions;

13 (7) drug-food interactions;

14 (8) drug-disease contraindications;

15 (9) identification of therapeutic duplication;

16 (10) patient laboratory values when authorized and  
17 available;

18 (11) proper utilization (including over or under  
19 utilization) and optimum therapeutic outcomes; and

20 (12) drug abuse and misuse.

21 "Medication therapy management services" includes the  
22 following:

23 (1) documenting the services delivered and  
24 communicating the information provided to patients'  
25 prescribers within an appropriate time frame, not to  
26 exceed 48 hours;

1           (2) providing patient counseling designed to enhance a  
2           patient's understanding and the appropriate use of his or  
3           her medications; and

4           (3) providing information, support services, and  
5           resources designed to enhance a patient's adherence with  
6           his or her prescribed therapeutic regimens.

7           "Medication therapy management services" may also include  
8           patient care functions authorized by a physician licensed to  
9           practice medicine in all its branches for his or her  
10          identified patient or groups of patients under specified  
11          conditions or limitations in a standing order from the  
12          physician.

13          "Medication therapy management services" in a licensed  
14          hospital may also include the following:

15                 (1) reviewing assessments of the patient's health  
16                 status; and

17                 (2) following protocols of a hospital pharmacy and  
18                 therapeutics committee with respect to the fulfillment of  
19                 medication orders.

20           (bb) "Pharmacist care" means the provision by a pharmacist  
21           of medication therapy management services, with or without the  
22           dispensing of drugs or devices, intended to achieve outcomes  
23           that improve patient health, quality of life, and comfort and  
24           enhance patient safety.

25           (cc) "Protected health information" means individually  
26           identifiable health information that, except as otherwise

1 provided, is:

2 (1) transmitted by electronic media;

3 (2) maintained in any medium set forth in the  
4 definition of "electronic media" in the federal Health  
5 Insurance Portability and Accountability Act; or

6 (3) transmitted or maintained in any other form or  
7 medium.

8 "Protected health information" does not include  
9 individually identifiable health information found in:

10 (1) education records covered by the federal Family  
11 Educational Right and Privacy Act; or

12 (2) employment records held by a licensee in its role  
13 as an employer.

14 (dd) "Standing order" means a specific order for a patient  
15 or group of patients issued by a physician licensed to  
16 practice medicine in all its branches in Illinois.

17 (ee) "Address of record" means the designated address  
18 recorded by the Department in the applicant's application file  
19 or licensee's license file maintained by the Department's  
20 licensure maintenance unit.

21 (ff) "Home pharmacy" means the location of a pharmacy's  
22 primary operations.

23 (gg) "Email address of record" means the designated email  
24 address recorded by the Department in the applicant's  
25 application file or the licensee's license file, as maintained  
26 by the Department's licensure maintenance unit.

1 (Source: P.A. 102-16, eff. 6-17-21; 102-103, eff. 1-1-22;  
2 102-558, eff. 8-20-21; 102-813, eff. 5-13-22; 102-1051, eff.  
3 1-1-23; 103-1, eff. 4-27-23.)

4 (225 ILCS 85/9.6)

5 Sec. 9.6. Administration of vaccines and therapeutics by  
6 registered pharmacy technicians and student pharmacists.

7 (a) Under the supervision of an appropriately trained  
8 pharmacist, a registered pharmacy technician or student  
9 pharmacist may administer COVID-19, SARS-CoV-2, respiratory  
10 syncytial virus, and influenza vaccines subcutaneously,  
11 intramuscularly, or orally as authorized, approved, or  
12 licensed by the United States Food and Drug Administration,  
13 subject to the following conditions:

14 (1) the vaccination must be ordered by the supervising  
15 pharmacist;

16 (2) the supervising pharmacist must be readily and  
17 immediately available to the immunizing pharmacy  
18 technician or student pharmacist;

19 (3) the pharmacy technician or student pharmacist must  
20 complete a practical training program that is approved by  
21 the Accreditation Council for Pharmacy Education and that  
22 includes hands-on injection technique training and  
23 training in the recognition and treatment of emergency  
24 reactions to vaccines;

25 (4) the pharmacy technician or student pharmacist must

1           have a current certificate in basic cardiopulmonary  
2           resuscitation;

3           (5) the pharmacy technician or student pharmacist must  
4           complete, during the relevant licensing period, a minimum  
5           of 2 hours of immunization-related continuing pharmacy  
6           education that is approved by the Accreditation Council  
7           for Pharmacy Education;

8           (6) the supervising pharmacist must comply with all  
9           relevant recordkeeping and reporting requirements;

10          (7) the supervising pharmacist must be responsible for  
11          complying with requirements related to reporting adverse  
12          events;

13          (8) the supervising pharmacist must review the vaccine  
14          registry or other vaccination records prior to ordering  
15          the vaccination to be administered by the pharmacy  
16          technician or student pharmacist;

17          (9) the pharmacy technician or student pharmacist  
18          must, if the patient is 18 years of age or younger, inform  
19          the patient and the adult caregiver accompanying the  
20          patient of the importance of a well-child visit with a  
21          pediatrician or other licensed primary-care provider and  
22          must refer patients as appropriate;

23          (10) in the case of a COVID-19 vaccine, the  
24          vaccination must be ordered and administered according to  
25          the Advisory Committee on Immunization Practices' COVID-19  
26          vaccine recommendations;

1           (11) in the case of a COVID-19 vaccine, the  
2           supervising pharmacist must comply with any applicable  
3           requirements or conditions of use as set forth in the  
4           Centers for Disease Control and Prevention COVID-19  
5           vaccination provider agreement and any other federal  
6           requirements that apply to the administration of COVID-19  
7           vaccines being administered; and

8           (12) the registered pharmacy technician or student  
9           pharmacist and the supervising pharmacist must comply with  
10          all other requirements of this Act and the rules adopted  
11          thereunder pertaining to the administration of drugs.

12          (b) Under the supervision of an appropriately trained  
13          pharmacist, a registered pharmacy technician or student  
14          pharmacist may administer COVID-19 therapeutics  
15          subcutaneously, intramuscularly, or orally as authorized,  
16          approved, or licensed by the United States Food and Drug  
17          Administration, subject to the following conditions:

18               (1) the COVID-19 therapeutic must be authorized,  
19               approved or licensed by the United States Food and Drug  
20               Administration;

21               (2) the COVID-19 therapeutic must be administered  
22               subcutaneously, intramuscularly, or orally in accordance  
23               with the United States Food and Drug Administration  
24               approval, authorization, or licensing;

25               (3) a pharmacy technician or student pharmacist  
26               practicing pursuant to this Section must complete a



1 practical training program that is approved by the  
2 Accreditation Council for Pharmacy Education and that  
3 includes hands-on injection technique training, clinical  
4 evaluation of indications and contraindications of  
5 COVID-19 therapeutics training, training in the  
6 recognition and treatment of emergency reactions to  
7 COVID-19 therapeutics, and any additional training  
8 required in the United States Food and Drug Administration  
9 approval, authorization, or licensing;

10 (4) the pharmacy technician or student pharmacist must  
11 have a current certificate in basic cardiopulmonary  
12 resuscitation;

13 (5) the pharmacy technician or student pharmacist must  
14 comply with any applicable requirements or conditions of  
15 use that apply to the administration of COVID-19  
16 therapeutics;

17 (6) the supervising pharmacist must comply with all  
18 relevant recordkeeping and reporting requirements;

19 (7) the supervising pharmacist must be readily and  
20 immediately available to the pharmacy technician or  
21 student pharmacist; and

22 (8) the registered pharmacy technician or student  
23 pharmacist and the supervising pharmacist must comply with  
24 all other requirements of this Act and the rules adopted  
25 thereunder pertaining to the administration of drugs.

26 (Source: P.A. 103-1, eff. 4-27-23.)

1

ARTICLE 999.

2

Section 999-99. Effective date. This Act takes effect upon

3

becoming law.