

1 AN ACT concerning regulation.

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

4 ARTICLE 1.

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

8 Section 1-5. Funding for licensed or certified
9 community-based substance use disorder treatment providers.
10 Subject to federal approval, beginning on January 1, 2024 for
11 State Fiscal Year 2024, and for each State fiscal year
12 thereafter, the General Assembly shall appropriate sufficient
13 funds to the Department of Human Services to ensure
14 reimbursement rates will be increased and subsequently
15 adjusted upward by an amount equal to the Consumer Price
16 Index-U from the previous year, not to exceed 5% in any State
17 fiscal year, for licensed or certified substance use disorder
18 treatment providers of ASAM Level 3 residential/inpatient
19 services under community service grant programs for persons
20 with substance use disorders.

21 If there is a decrease in the Consumer Price Index-U,
22 rates shall remain unchanged for that State fiscal year. The

1 Department of Human Services shall increase the grant contract
2 amount awarded to each eligible community-based substance use
3 disorder treatment provider to ensure that the level and
4 number of services provided under community service grant
5 programs shall not be reduced by increasing the amount
6 available to each provider under the community service grant
7 programs to address the increased rate for each such service.

8 The Department shall adopt rules, including emergency
9 rules in accordance with Section 5-45 of the Illinois
10 Administrative Procedure Act, to implement the provisions of
11 this Act.

12 As used in this Act, "Consumer Price Index-U" means the
13 index published by the Bureau of Labor Statistics of the
14 United States Department of Labor that measures the average
15 change in prices of goods and services purchased by all urban
16 consumers, United States city average, all items, 1982-84 =
17 100.

18 ARTICLE 5.

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

21 (5 ILCS 100/5-45.35 new)

22 Sec. 5-45.35. Emergency rulemaking; Substance Use Disorder
23 Residential and Detox Rate Equity. To provide for the

1 expeditious and timely implementation of the Substance Use
2 Disorder Residential and Detox Rate Equity Act, emergency
3 rules implementing the Substance Use Disorder Residential and
4 Detox Rate Equity Act may be adopted in accordance with
5 Section 5-45 by the Department of Human Services and the
6 Department of Healthcare and Family Services. The adoption of
7 emergency rules authorized by Section 5-45 and this Section is
8 deemed to be necessary for the public interest, safety, and
9 welfare.

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

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

14 (20 ILCS 301/55-30)

15 Sec. 55-30. Rate increase.

16 (a) The Department shall by rule develop the increased
17 rate methodology and annualize the increased rate beginning
18 with State fiscal year 2018 contracts to licensed providers of
19 community-based substance use disorder intervention or
20 treatment, based on the additional amounts appropriated for
21 the purpose of providing a rate increase to licensed
22 providers. The Department shall adopt rules, including
23 emergency rules under subsection (y) of Section 5-45 of the
24 Illinois Administrative Procedure Act, to implement the

1 provisions of this Section.

2 (b) (Blank).

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

8 (1) Admission and Discharge Assessment.

9 (2) Level 1 (Individual).

10 (3) Level 1 (Group).

11 (4) Level 2 (Individual).

12 (5) Level 2 (Group).

13 (6) Case Management.

14 (7) Psychiatric Evaluation.

15 (8) Medication Assisted Recovery.

16 (9) Community Intervention.

17 (10) Early Intervention (Individual).

18 (11) Early Intervention (Group).

19 Beginning in State Fiscal Year 2023, and every State
20 fiscal year thereafter, reimbursement rates for those
21 community-based substance use disorder treatment and
22 intervention services shall be adjusted upward by an amount
23 equal to the Consumer Price Index-U from the previous year,
24 not to exceed 2% in any State fiscal year. If there is a
25 decrease in the Consumer Price Index-U, rates shall remain
26 unchanged for that State fiscal year. The Department shall

1 adopt rules, including emergency rules in accordance with the
2 Illinois Administrative Procedure Act, to implement the
3 provisions of this Section.

4 As used in this subsection, "consumer price index-u" means
5 the index published by the Bureau of Labor Statistics of the
6 United States Department of Labor that measures the average
7 change in prices of goods and services purchased by all urban
8 consumers, United States city average, all items, 1982-84 =
9 100.

10 (d) Beginning on January 1, 2024, subject to federal
11 approval, the Division of Substance Use Prevention and
12 Recovery shall increase reimbursement rates for all ASAM level
13 3 residential/inpatient substance use disorder treatment and
14 intervention services by 30%, including, but not limited to,
15 the following services:

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

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

20 (3) ASAM level 3.2 Clinically Managed Residential
21 Withdrawal Management;

22 (4) ASAM level 3.7 Medically Monitored Intensive
23 Inpatient Services for adults and Medically Monitored
24 High-Intensity Inpatient Services for adolescents; and

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

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

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

4 (305 ILCS 5/5-47 new)

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

7 (a) Beginning on January 1, 2024, subject to federal
8 approval, the Department of Healthcare and Family Services, in
9 conjunction with the Department of Human Services' Division of
10 Substance Use Prevention and Recovery, shall provide a 30%
11 increase in reimbursement rates for all Medicaid-covered ASAM
12 Level 3 residential/inpatient substance use disorder treatment
13 services.

14 No existing or future reimbursement rates or add-ons shall
15 be reduced or changed to address this proposed rate increase.
16 No later than 3 months after the effective date of this
17 amendatory Act of the 103rd General Assembly, the Department
18 of Healthcare and Family Services shall submit any necessary
19 application to the federal Centers for Medicare and Medicaid
20 Services to implement the requirements of this Section.

21 (b) Parity in community-based behavioral health rates;
22 implementation plan for cost reporting. For the purpose of
23 understanding behavioral health services cost structures and
24 their impact on the Medical Assistance Program, the Department

1 of Healthcare and Family Services shall engage stakeholders to
2 develop a plan for the regular collection of cost reporting
3 for all entity-based substance use disorder providers. Data
4 shall be used to inform on the effectiveness and efficiency of
5 Illinois Medicaid rates. The Department and stakeholders shall
6 develop a plan by April 1, 2024. The Department shall engage
7 stakeholders on implementation of the plan. The plan, at
8 minimum, shall consider all of the following:

9 (1) Alignment with certified community behavioral
10 health clinic requirements, standards, policies, and
11 procedures.

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

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

16 (4) Consideration of additional administrative time
17 and costs.

18 (5) Goals, purposes, and usage of data collected from
19 cost reports.

20 (6) Inclusion of qualitative data in addition to
21 quantitative data.

22 (7) Technical assistance for providers for completing
23 cost reports including initial training by the Department
24 for providers.

25 (8) Implementation of a timeline which allows an
26 initial grace period for providers to adjust internal

1 procedures and data collection.

2 Details from collected cost reports shall be made publicly
3 available on the Department's website and costs shall be used
4 to ensure the effectiveness and efficiency of Illinois
5 Medicaid rates.

6 (c) Reporting; access to substance use disorder treatment
7 services and recovery supports. By no later than April 1,
8 2024, the Department of Healthcare and Family Services, with
9 input from the Department of Human Services' Division of
10 Substance Use Prevention and Recovery, shall submit a report
11 to the General Assembly regarding access to treatment services
12 and recovery supports for persons diagnosed with a substance
13 use disorder. The report shall include, but is not limited to,
14 the following information:

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

19 (2) The number of Medicaid customers in Illinois with
20 a diagnosed substance use disorder receiving substance use
21 disorder treatment, aggregated by provider type and ASAM
22 level of care.

23 (3) A comparison of Illinois' substance use disorder
24 licensure and certification requirements with those of
25 comparable state Medicaid programs.

26 (4) Recommendations for and an analysis of the impact

1 of aligning reimbursement rates for outpatient substance
2 use disorder treatment services with reimbursement rates
3 for community-based mental health treatment services.

4 (5) Recommendations for expanding substance use
5 disorder treatment to other qualified provider entities
6 and licensed professionals of the healing arts. The
7 recommendations shall include an analysis of the
8 opportunities to maximize the flexibilities permitted by
9 the federal Centers for Medicare and Medicaid Services for
10 expanding access to the number and types of qualified
11 substance use disorder providers.

12 ARTICLE 10.

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

15 (5 ILCS 100/5-45.36 new)

16 Sec. 5-45.36. Emergency rulemaking; Medicaid reimbursement
17 rates for hospital inpatient and outpatient services. To
18 provide for the expeditious and timely implementation of the
19 changes made by this amendatory Act of the 103rd General
20 Assembly to Sections 5-5.05, 14-12, 14-12.5, and 14-12.7 of
21 the Illinois Public Aid Code, emergency rules implementing the
22 changes made by this amendatory Act of the 103rd General
23 Assembly to Sections 5-5.05, 14-12, 14-12.5, and 14-12.7 of

1 the Illinois Public Aid Code may be adopted in accordance with
2 Section 5-45 by the Department of Healthcare and Family
3 Services. The adoption of emergency rules authorized by
4 Section 5-45 and this Section is deemed to be necessary for the
5 public interest, safety, and welfare.

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

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

11 (305 ILCS 5/5-5.05)

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

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

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

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

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

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

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

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

1 ~~(6) Lawrence County Memorial Hospital, Lawrenceville,~~
2 ~~Illinois.~~

3 ~~(7) Advocate Lutheran General Hospital, Park Ridge,~~
4 ~~Illinois.~~

5 ~~(8) Mercy Hospital and Medical Center, Chicago,~~
6 ~~Illinois.~~

7 ~~(9) Methodist Medical Center of Illinois, Peoria,~~
8 ~~Illinois.~~

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

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

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

14 ~~(13) Provena Covenant Medical Center, Urbana,~~
15 ~~Illinois.~~

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

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

19 ~~(16) Gateway Regional Medical Center, Granite City,~~
20 ~~Illinois.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

8 ~~(30) Kenneth Hall Regional Hospital, East St. Louis,~~
9 ~~Illinois.~~

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

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

12 ~~(33) University of Chicago Medical Center, Chicago,~~
13 ~~Illinois.~~

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

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

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

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

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

24 (b-5) Notwithstanding any other provision of this Section,
25 ~~and subject to appropriation,~~ the inpatient, per diem rate to
26 be paid to all safety-net hospitals for inpatient psychiatric

1 services on and after January 1, 2021 shall be at least \$630,
2 subject to the provisions of Section 14-12.5.

3 (b-10) Notwithstanding any other provision of this
4 Section, effective with dates of service on and after January
5 1, 2022, any general acute care hospital with more than 9,500
6 inpatient psychiatric Medicaid days in any calendar year shall
7 be paid the inpatient per diem rate of no less than \$630,
8 subject to the provisions of Section 14-12.5.

9 (c) No rules shall be promulgated to implement this
10 Section. For purposes of this Section, "rules" is given the
11 meaning contained in Section 1-70 of the Illinois
12 Administrative Procedure Act.

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

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

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

24 (305 ILCS 5/5A-12.7)

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

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

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

22 (b) Amounts moved into claims-based rates and distributed
23 in accordance with Section 14-12 shall remain in those
24 claims-based rates.

25 (c) Graduate medical education.

26 (1) The calculation of graduate medical education

1 payments shall be based on the hospital's Medicare cost
2 report ending in Calendar Year 2018, as reported in the
3 Healthcare Cost Report Information System file, release
4 date September 30, 2019. An Illinois hospital reporting
5 intern and resident cost on its Medicare cost report shall
6 be eligible for graduate medical education payments.

7 (2) Each hospital's annualized Medicaid Intern
8 Resident Cost is calculated using annualized intern and
9 resident total costs obtained from Worksheet B Part I,
10 Columns 21 and 22 the sum of Lines 30-43, 50-76, 90-93,
11 96-98, and 105-112 multiplied by the percentage that the
12 hospital's Medicaid days (Worksheet S3 Part I, Column 7,
13 Lines 2, 3, 4, 14, 16-18, and 32) comprise of the
14 hospital's total days (Worksheet S3 Part I, Column 8,
15 Lines 14, 16-18, and 32).

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

23 (4) For each hospital, its annualized Medicaid Intern
24 Resident Cost and its annualized Medicaid IME payment are
25 summed, and, except as capped at 120% of the average cost
26 per intern and resident for all qualifying hospitals as

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

14 (A) For the period of July 1, 2020 through
15 December 31, 2022, the applicable reimbursement factor
16 shall be 22.6%.

17 (B) For the period of January 1, 2023 through
18 December 31, 2026, the applicable reimbursement factor
19 shall be 35% for all qualified safety-net hospitals,
20 as defined in Section 5-5e.1 of this Code, and all
21 hospitals with 100 or more Full Time Equivalent
22 Residents and Interns, as reported on the hospital's
23 Medicare cost report ending in Calendar Year 2018, and
24 for all other qualified hospitals the applicable
25 reimbursement factor shall be 30%.

26 (d) Fee-for-service supplemental payments. For the period

1 of July 1, 2020 through December 31, 2022, each Illinois
2 hospital shall receive an annual payment equal to the amounts
3 below, to be paid in 12 equal installments on or before the
4 seventh State business day of each month, except that no
5 payment shall be due within 30 days after the later of the date
6 of notification of federal approval of the payment
7 methodologies required under this Section or any waiver
8 required under 42 CFR 433.68, at which time the sum of amounts
9 required under this Section prior to the date of notification
10 is due and payable.

11 (1) For critical access hospitals, \$385 per covered
12 inpatient day contained in paid fee-for-service claims and
13 \$530 per paid fee-for-service outpatient claim for dates
14 of service in Calendar Year 2019 in the Department's
15 Enterprise Data Warehouse as of May 11, 2020.

16 (2) For safety-net hospitals, \$960 per covered
17 inpatient day contained in paid fee-for-service claims and
18 \$625 per paid fee-for-service outpatient claim for dates
19 of service in Calendar Year 2019 in the Department's
20 Enterprise Data Warehouse as of May 11, 2020.

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

25 (4) For freestanding psychiatric hospitals, \$125 per
26 covered inpatient day contained in paid fee-for-service

1 claims and \$130 per paid fee-for-service outpatient claim
2 for dates of service in Calendar Year 2019 in the
3 Department's Enterprise Data Warehouse as of May 11, 2020.

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

9 (6) For all general acute care hospitals and high
10 Medicaid hospitals as defined in subsection (f), \$350 per
11 covered inpatient day for dates of service in Calendar
12 Year 2019 contained in paid fee-for-service claims and
13 \$620 per paid fee-for-service outpatient claim in the
14 Department's Enterprise Data Warehouse as of May 11, 2020.

15 (7) Alzheimer's treatment access payment. Each
16 Illinois academic medical center or teaching hospital, as
17 defined in Section 5-5e.2 of this Code, that is identified
18 as the primary hospital affiliate of one of the Regional
19 Alzheimer's Disease Assistance Centers, as designated by
20 the Alzheimer's Disease Assistance Act and identified in
21 the Department of Public Health's Alzheimer's Disease
22 State Plan dated December 2016, shall be paid an
23 Alzheimer's treatment access payment equal to the product
24 of the qualifying hospital's State Fiscal Year 2018 total
25 inpatient fee-for-service days multiplied by the
26 applicable Alzheimer's treatment rate of \$226.30 for

1 hospitals located in Cook County and \$116.21 for hospitals
2 located outside Cook County.

3 (d-2) Fee-for-service supplemental payments. Beginning
4 January 1, 2023, each Illinois hospital shall receive an
5 annual payment equal to the amounts listed below, to be paid in
6 12 equal installments on or before the seventh State business
7 day of each month, except that no payment shall be due within
8 30 days after the later of the date of notification of federal
9 approval of the payment methodologies required under this
10 Section or any waiver required under 42 CFR 433.68, at which
11 time the sum of amounts required under this Section prior to
12 the date of notification is due and payable. The Department
13 may adjust the rates in paragraphs (1) through (7) to comply
14 with the federal upper payment limits, with such adjustments
15 being determined so that the total estimated spending by
16 hospital class, under such adjusted rates, remains
17 substantially similar to the total estimated spending under
18 the original rates set forth in this subsection.

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

25 (2) For safety-net hospitals, as described in
26 subsection (f), \$1,350 per inpatient day contained in paid

1 fee-for-service claims and \$1,350 per paid fee-for-service
2 outpatient claim for dates of service in Calendar Year
3 2019 in the Department's Enterprise Data Warehouse as of
4 August 6, 2021.

5 (3) For long term acute care hospitals, \$550 per
6 covered inpatient day contained in paid fee-for-service
7 claims for dates of service in Calendar Year 2019 in the
8 Department's Enterprise Data Warehouse as of August 6,
9 2021.

10 (4) For freestanding psychiatric hospitals, \$200 per
11 covered inpatient day contained in paid fee-for-service
12 claims and \$200 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 August 6,
15 2021.

16 (5) For freestanding rehabilitation hospitals, \$550
17 per covered inpatient day contained in paid
18 fee-for-service claims and \$125 per paid fee-for-service
19 outpatient claim for dates of service in Calendar Year
20 2019 in the Department's Enterprise Data Warehouse as of
21 August 6, 2021.

22 (6) For all general acute care hospitals and high
23 Medicaid hospitals as defined in subsection (f), \$500 per
24 covered inpatient day for dates of service in Calendar
25 Year 2019 contained in paid fee-for-service claims and
26 \$500 per paid fee-for-service outpatient claim in the

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

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

9 (8) Alzheimer's treatment access payment. Each
10 Illinois academic medical center or teaching hospital, as
11 defined in Section 5-5e.2 of this Code, that is identified
12 as the primary hospital affiliate of one of the Regional
13 Alzheimer's Disease Assistance Centers, as designated by
14 the Alzheimer's Disease Assistance Act and identified in
15 the Department of Public Health's Alzheimer's Disease
16 State Plan dated December 2016, shall be paid an
17 Alzheimer's treatment access payment equal to the product
18 of the qualifying hospital's Calendar Year 2019 total
19 inpatient fee-for-service days, in the Department's
20 Enterprise Data Warehouse as of August 6, 2021, multiplied
21 by the applicable Alzheimer's treatment rate of \$244.37
22 for hospitals located in Cook County and \$312.03 for
23 hospitals located outside Cook County.

24 (e) The Department shall require managed care
25 organizations (MCOs) to make directed payments and
26 pass-through payments according to this Section. Each calendar

1 year, the Department shall require MCOs to pay the maximum
2 amount out of these funds as allowed as pass-through payments
3 under federal regulations. The Department shall require MCOs
4 to make such pass-through payments as specified in this
5 Section. The Department shall require the MCOs to pay the
6 remaining amounts as directed Payments as specified in this
7 Section. The Department shall issue payments to the
8 Comptroller by the seventh business day of each month for all
9 MCOs that are sufficient for MCOs to make the directed
10 payments and pass-through payments according to this Section.
11 The Department shall require the MCOs to make pass-through
12 payments and directed payments using electronic funds
13 transfers (EFT), if the hospital provides the information
14 necessary to process such EFTs, in accordance with directions
15 provided monthly by the Department, within 7 business days of
16 the date the funds are paid to the MCOs, as indicated by the
17 "Paid Date" on the website of the Office of the Comptroller if
18 the funds are paid by EFT and the MCOs have received directed
19 payment instructions. If funds are not paid through the
20 Comptroller by EFT, payment must be made within 7 business
21 days of the date actually received by the MCO. The MCO will be
22 considered to have paid the pass-through payments when the
23 payment remittance number is generated or the date the MCO
24 sends the check to the hospital, if EFT information is not
25 supplied. If an MCO is late in paying a pass-through payment or
26 directed payment as required under this Section (including any

1 extensions granted by the Department), it shall pay a penalty,
2 unless waived by the Department for reasonable cause, to the
3 Department equal to 5% of the amount of the pass-through
4 payment or directed payment not paid on or before the due date
5 plus 5% of the portion thereof remaining unpaid on the last day
6 of each 30-day period thereafter. Payments to MCOs that would
7 be paid consistent with actuarial certification and enrollment
8 in the absence of the increased capitation payments under this
9 Section shall not be reduced as a consequence of payments made
10 under this subsection. The Department shall publish and
11 maintain on its website for a period of no less than 8 calendar
12 quarters, the quarterly calculation of directed payments and
13 pass-through payments owed to each hospital from each MCO. All
14 calculations and reports shall be posted no later than the
15 first day of the quarter for which the payments are to be
16 issued.

17 (f)(1) For purposes of allocating the funds included in
18 capitation payments to MCOs, Illinois hospitals shall be
19 divided into the following classes as defined in
20 administrative rules:

21 (A) Beginning July 1, 2020 through December 31, 2022,
22 critical access hospitals. Beginning January 1, 2023,
23 "critical access hospital" means a hospital designated by
24 the Department of Public Health as a critical access
25 hospital, excluding any hospital meeting the definition of
26 a public hospital in subparagraph (F).

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

9 (C) Long term acute care hospitals.

10 (D) Freestanding psychiatric hospitals.

11 (E) Freestanding rehabilitation hospitals.

12 (F) Beginning January 1, 2023, "public hospital" means
13 a hospital that is owned or operated by an Illinois
14 Government body or municipality, excluding a hospital
15 provider that is a State agency, a State university, or a
16 county with a population of 3,000,000 or more.

17 (G) High Medicaid hospitals.

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

20 (I) For the payout periods July 1, 2020
21 through December 31, 2022, is not a safety-net
22 hospital or critical access hospital and that has
23 a Medicaid Inpatient Utilization Rate above 30% or
24 a hospital that had over 35,000 inpatient Medicaid
25 days during the applicable period. For the period
26 July 1, 2020 through December 31, 2020, the

1 applicable period for the Medicaid Inpatient
2 Utilization Rate (MIUR) is the rate year 2020 MIUR
3 and for the number of inpatient days it is State
4 fiscal year 2018. Beginning in calendar year 2021,
5 the Department shall use the most recently
6 determined MIUR, as defined in subsection (h) of
7 Section 5-5.02, and for the inpatient day
8 threshold, the State fiscal year ending 18 months
9 prior to the beginning of the calendar year. For
10 purposes of calculating MIUR under this Section,
11 children's hospitals and affiliated general acute
12 care hospitals shall be considered a single
13 hospital.

14 (II) For the calendar year beginning January
15 1, 2023, and each calendar year thereafter, is not
16 a public hospital, safety-net hospital, or
17 critical access hospital and that qualifies as a
18 regional high volume hospital or is a hospital
19 that has a Medicaid Inpatient Utilization Rate
20 (MIUR) above 30%. As used in this item, "regional
21 high volume hospital" means a hospital which ranks
22 in the top 2 quartiles based on total hospital
23 services volume, of all eligible general acute
24 care hospitals, when ranked in descending order
25 based on total hospital services volume, within
26 the same Medicaid managed care region, as

1 designated by the Department, as of January 1,
2 2022. As used in this item, "total hospital
3 services volume" means the total of all Medical
4 Assistance hospital inpatient admissions plus all
5 Medical Assistance hospital outpatient visits. For
6 purposes of determining regional high volume
7 hospital inpatient admissions and outpatient
8 visits, the Department shall use dates of service
9 provided during State Fiscal Year 2020 for the
10 Payout Quarter beginning January 1, 2023. The
11 Department shall use dates of service from the
12 State fiscal year ending 18 month before the
13 beginning of the first Payout Quarter of the
14 subsequent annual determination period.

15 (ii) For the calendar year beginning January 1,
16 2023, the Department shall use the Rate Year 2022
17 Medicaid inpatient utilization rate (MIUR), as defined
18 in subsection (h) of Section 5-5.02. For each
19 subsequent annual determination, the Department shall
20 use the MIUR applicable to the rate year ending
21 September 30 of the year preceding the beginning of
22 the calendar year.

23 (H) General acute care hospitals. As used under this
24 Section, "general acute care hospitals" means all other
25 Illinois hospitals not identified in subparagraphs (A)
26 through (G).

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

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

17 (g) Fixed pool directed payments. Beginning July 1, 2020,
18 the Department shall issue payments to MCOs which shall be
19 used to issue directed payments to qualified Illinois
20 safety-net hospitals and critical access hospitals on a
21 monthly basis in accordance with this subsection. Prior to the
22 beginning of each Payout Quarter beginning July 1, 2020, the
23 Department shall use encounter claims data from the
24 Determination Quarter, accepted by the Department's Medicaid
25 Management Information System for inpatient and outpatient
26 services rendered by safety-net hospitals and critical access

1 hospitals to determine a quarterly uniform per unit add-on for
2 each hospital class.

3 (1) Inpatient per unit add-on. A quarterly uniform per
4 diem add-on shall be derived by dividing the quarterly
5 Inpatient Directed Payments Pool amount allocated to the
6 applicable hospital class by the total inpatient days
7 contained on all encounter claims received during the
8 Determination Quarter, for all hospitals in the class.

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

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

20 (2) Outpatient per unit add-on. A quarterly uniform
21 per claim add-on shall be derived by dividing the
22 quarterly Outpatient Directed Payments Pool amount
23 allocated to the applicable hospital class by the total
24 outpatient encounter claims received during the
25 Determination Quarter, for all hospitals in the class.

26 (A) Each hospital in the class shall have a

1 quarterly outpatient directed payment calculated that
2 is equal to the product of the number of outpatient
3 encounter claims attributable to the hospital used in
4 the calculation of the quarterly uniform class per
5 claim add-on, multiplied by the calculated applicable
6 quarterly uniform class per claim add-on of the
7 hospital class.

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

12 (3) Each MCO shall pay each hospital the Monthly
13 Directed Payment as identified by the Department on its
14 quarterly determination report.

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

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

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

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

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

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

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

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

7 (6) For the period January 1, 2023 through December
8 31, 2023, the Department shall establish the amounts that
9 shall be allocated to the hospital class directed payment
10 fixed pools identified in this paragraph for the quarterly
11 development of a uniform per unit add-on. The Department
12 shall establish such amounts so that the total amount of
13 payments to each hospital under this Section in calendar
14 year 2023 is projected to be substantially similar to the
15 total amount of such payments received by the hospital
16 under this Section in calendar year 2021, adjusted for
17 increased funding provided for fixed pool directed
18 payments under subsection (g) in calendar year 2022,
19 assuming that the volume and acuity of claims are held
20 constant. The Department shall publish the directed
21 payment fixed pool amounts to be established under this
22 paragraph on its website by November 15, 2022.

23 (A) Hospital inpatient services for critical
24 access hospitals.

25 (B) Hospital outpatient services for critical
26 access hospitals.

1 (C) Hospital inpatient services for public
2 hospitals.

3 (D) Hospital outpatient services for public
4 hospitals.

5 (E) Hospital inpatient services for safety-net
6 hospitals.

7 (F) Hospital outpatient services for safety-net
8 hospitals.

9 (7) Semi-annual rate maintenance review. The
10 Department shall ensure that hospitals assigned to the
11 fixed pools in paragraph (6) are paid no less than 95% of
12 the annual initial rate for each 6-month period of each
13 annual payout period. For each calendar year, the
14 Department shall calculate the annual initial rate per day
15 and per visit for each fixed pool hospital class listed in
16 paragraph (6), by dividing the total of all applicable
17 inpatient or outpatient directed payments issued in the
18 preceding calendar year to the hospitals in each fixed
19 pool class for the calendar year, plus any increase
20 resulting from the annual adjustments described in
21 subsection (i), by the actual applicable total service
22 units for the preceding calendar year which were the basis
23 of the total applicable inpatient or outpatient directed
24 payments issued to the hospitals in each fixed pool class
25 in the calendar year, except that for calendar year 2023,
26 the service units from calendar year 2021 shall be used.

1 (A) The Department shall calculate the effective
2 rate, per day and per visit, for the payout periods of
3 January to June and July to December of each year, for
4 each fixed pool listed in paragraph (6), by dividing
5 50% of the annual pool by the total applicable
6 reported service units for the 2 applicable
7 determination quarters.

8 (B) If the effective rate calculated in
9 subparagraph (A) is less than 95% of the annual
10 initial rate assigned to the class for each pool under
11 paragraph (6), the Department shall adjust the payment
12 for each hospital to a level equal to no less than 95%
13 of the annual initial rate, by issuing a retroactive
14 adjustment payment for the 6-month period under review
15 as identified in subparagraph (A).

16 (h) Fixed rate directed payments. Effective July 1, 2020,
17 the Department shall issue payments to MCOs which shall be
18 used to issue directed payments to Illinois hospitals not
19 identified in paragraph (g) on a monthly basis. Prior to the
20 beginning of each Payout Quarter beginning July 1, 2020, the
21 Department shall use encounter claims data from the
22 Determination Quarter, accepted by the Department's Medicaid
23 Management Information System for inpatient and outpatient
24 services rendered by hospitals in each hospital class
25 identified in paragraph (f) and not identified in paragraph
26 (g). For the period July 1, 2020 through December 2020, the

1 Department shall direct MCOs to make payments as follows:

2 (1) For general acute care hospitals an amount equal
3 to \$1,750 multiplied by the hospital's category of service
4 20 case mix index for the determination quarter multiplied
5 by the hospital's total number of inpatient admissions for
6 category of service 20 for the determination quarter.

7 (2) For general acute care hospitals an amount equal
8 to \$160 multiplied by the hospital's category of service
9 21 case mix index for the determination quarter multiplied
10 by the hospital's total number of inpatient admissions for
11 category of service 21 for the determination quarter.

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

17 (4) For general acute care hospitals an amount equal
18 to \$375 multiplied by the hospital's category of service
19 24 case mix index for the determination quarter multiplied
20 by the hospital's total number of category of service 24
21 paid EAPG (EAPGs) for the determination quarter.

22 (5) For general acute care hospitals an amount equal
23 to \$240 multiplied by the hospital's category of service
24 27 and 28 case mix index for the determination quarter
25 multiplied by the hospital's total number of category of
26 service 27 and 28 paid EAPGs for the determination

1 quarter.

2 (6) For general acute care hospitals an amount equal
3 to \$290 multiplied by the hospital's category of service
4 29 case mix index for the determination quarter multiplied
5 by the hospital's total number of category of service 29
6 paid EAPGs for the determination quarter.

7 (7) For high Medicaid hospitals an amount equal to
8 \$1,800 multiplied by the hospital's category of service 20
9 case mix index for the determination quarter multiplied by
10 the hospital's total number of inpatient admissions for
11 category of service 20 for the determination quarter.

12 (8) For high Medicaid hospitals an amount equal to
13 \$160 multiplied by the hospital's category of service 21
14 case mix index for the determination quarter multiplied by
15 the hospital's total number of inpatient admissions for
16 category of service 21 for the determination quarter.

17 (9) For high Medicaid hospitals an amount equal to \$80
18 multiplied by the hospital's category of service 22 case
19 mix index for the determination quarter multiplied by the
20 hospital's total number of inpatient admissions for
21 category of service 22 for the determination quarter.

22 (10) For high Medicaid hospitals an amount equal to
23 \$400 multiplied by the hospital's category of service 24
24 case mix index for the determination quarter multiplied by
25 the hospital's total number of category of service 24 paid
26 EAPG outpatient claims for the determination quarter.

1 (11) For high Medicaid hospitals an amount equal to
2 \$240 multiplied by the hospital's category of service 27
3 and 28 case mix index for the determination quarter
4 multiplied by the hospital's total number of category of
5 service 27 and 28 paid EAPGs for the determination
6 quarter.

7 (12) For high Medicaid hospitals an amount equal to
8 \$290 multiplied by the hospital's category of service 29
9 case mix index for the determination quarter multiplied by
10 the hospital's total number of category of service 29 paid
11 EAPGs for the determination quarter.

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

15 (14) For psychiatric hospitals the amount of \$210
16 multiplied by the hospital's total number of inpatient
17 days for category of service 21 for the determination
18 quarter.

19 (15) For psychiatric hospitals the amount of \$250
20 multiplied by the hospital's total number of outpatient
21 claims for category of service 27 and 28 for the
22 determination quarter.

23 (16) For rehabilitation hospitals the amount of \$410
24 multiplied by the hospital's total number of inpatient
25 days for category of service 22 for the determination
26 quarter.

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

5 (18) Effective for the Payout Quarter beginning
6 January 1, 2023, for the directed payments to hospitals
7 required under this subsection, the Department shall
8 establish the amounts that shall be used to calculate such
9 directed payments using the methodologies specified in
10 this paragraph. The Department shall use a single, uniform
11 rate, adjusted for acuity as specified in paragraphs (1)
12 through (12), for all categories of inpatient services
13 provided by each class of hospitals and a single uniform
14 rate, adjusted for acuity as specified in paragraphs (1)
15 through (12), for all categories of outpatient services
16 provided by each class of hospitals. The Department shall
17 establish such amounts so that the total amount of
18 payments to each hospital under this Section in calendar
19 year 2023 is projected to be substantially similar to the
20 total amount of such payments received by the hospital
21 under this Section in calendar year 2021, adjusted for
22 increased funding provided for fixed pool directed
23 payments under subsection (g) in calendar year 2022,
24 assuming that the volume and acuity of claims are held
25 constant. The Department shall publish the directed
26 payment amounts to be established under this subsection on

1 its website by November 15, 2022.

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

6 20 Each MCO shall pay each hospital the Monthly
7 Directed Payment amount as identified by the Department on
8 its quarterly determination report.

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

19 Definitions. As used in this subsection:

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

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

25 (C) "Case mix index" means a hospital specific
26 calculation. For inpatient claims the case mix index

1 is calculated each quarter by summing the relative
2 weight of all inpatient Diagnosis-Related Group (DRG)
3 claims for a category of service in the applicable
4 Determination Quarter and dividing the sum by the
5 number of sum total of all inpatient DRG admissions
6 for the category of service for the associated claims.
7 The case mix index for outpatient claims is calculated
8 each quarter by summing the relative weight of all
9 paid EAPGs in the applicable Determination Quarter and
10 dividing the sum by the sum total of paid EAPGs for the
11 associated claims.

12 (i) Beginning January 1, 2021, the rates for directed
13 payments shall be recalculated in order to spend the
14 additional funds for directed payments that result from
15 reduction in the amount of pass-through payments allowed under
16 federal regulations. The additional funds for directed
17 payments shall be allocated proportionally to each class of
18 hospitals based on that class' proportion of services.

19 (1) Beginning January 1, 2024, the fixed pool directed
20 payment amounts and the associated annual initial rates
21 referenced in paragraph (6) of subsection (f) for each
22 hospital class shall be uniformly increased by a ratio of
23 not less than, the ratio of the total pass-through
24 reduction amount pursuant to paragraph (4) of subsection
25 (j), for the hospitals comprising the hospital fixed pool
26 directed payment class for the next calendar year, to the

1 total inpatient and outpatient directed payments for the
2 hospitals comprising the hospital fixed pool directed
3 payment class paid during the preceding calendar year.

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

15 (j) Pass-through payments.

16 (1) For the period July 1, 2020 through December 31,
17 2020, the Department shall assign quarterly pass-through
18 payments to each class of hospitals equal to one-fourth of
19 the following annual allocations:

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

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

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

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

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

25 (F) \$40,825,444 to freestanding psychiatric
26 hospitals.

1 (G) \$9,652,108 to freestanding rehabilitation
2 hospitals.

3 (2) For the period of July 1, 2020 through December
4 31, 2020, the pass-through payments shall at a minimum
5 ensure hospitals receive a total amount of monthly
6 payments under this Section as received in calendar year
7 2019 in accordance with this Article and paragraph (1) of
8 subsection (d-5) of Section 14-12, exclusive of amounts
9 received through payments referenced in subsection (b).

10 (3) For the calendar year beginning January 1, 2023,
11 the Department shall establish the annual pass-through
12 allocation to each class of hospitals and the pass-through
13 payments to each hospital so that the total amount of
14 payments to each hospital under this Section in calendar
15 year 2023 is projected to be substantially similar to the
16 total amount of such payments received by the hospital
17 under this Section in calendar year 2021, adjusted for
18 increased funding provided for fixed pool directed
19 payments under subsection (g) in calendar year 2022,
20 assuming that the volume and acuity of claims are held
21 constant. The Department shall publish the pass-through
22 allocation to each class and the pass-through payments to
23 each hospital to be established under this subsection on
24 its website by November 15, 2022.

25 (4) For the calendar years beginning January 1, 2021
26 ~~and, January 1, 2022, and January 1, 2024, and each~~

1 ~~calendar year thereafter,~~ each hospital's pass-through
2 payment amount shall be reduced proportionally to the
3 reduction of all pass-through payments required by federal
4 regulations. Beginning January 1, 2024, the Department
5 shall reduce total pass-through payments by the minimum
6 amount necessary to comply with federal regulations.
7 Pass-through payments to safety-net hospitals as defined
8 in Section 5-5e.1 of this Code, shall not be reduced until
9 all pass-through payments to other hospitals have been
10 eliminated. All other hospitals shall have their
11 pass-through payments reduced proportionally.

12 (k) At least 30 days prior to each calendar year, the
13 Department shall notify each hospital of changes to the
14 payment methodologies in this Section, including, but not
15 limited to, changes in the fixed rate directed payment rates,
16 the aggregate pass-through payment amount for all hospitals,
17 and the hospital's pass-through payment amount for the
18 upcoming calendar year.

19 (l) Notwithstanding any other provisions of this Section,
20 the Department may adopt rules to change the methodology for
21 directed and pass-through payments as set forth in this
22 Section, but only to the extent necessary to obtain federal
23 approval of a necessary State Plan amendment or Directed
24 Payment Preprint or to otherwise conform to federal law or
25 federal regulation.

26 (m) As used in this subsection, "managed care

1 organization" or "MCO" means an entity which contracts with
2 the Department to provide services where payment for medical
3 services is made on a capitated basis, excluding contracted
4 entities for dual eligible or Department of Children and
5 Family Services youth populations.

6 (n) In order to address the escalating infant mortality
7 rates among minority communities in Illinois, the State shall,
8 subject to appropriation, create a pool of funding of at least
9 \$50,000,000 annually to be disbursed among safety-net
10 hospitals that maintain perinatal designation from the
11 Department of Public Health. The funding shall be used to
12 preserve or enhance OB/GYN services or other specialty
13 services at the receiving hospital, with the distribution of
14 funding to be established by rule and with consideration to
15 perinatal hospitals with safe birthing levels and quality
16 metrics for healthy mothers and babies.

17 (o) In order to address the growing challenges of
18 providing stable access to healthcare in rural Illinois,
19 including perinatal services, behavioral healthcare including
20 substance use disorder services (SUDs) and other specialty
21 services, and to expand access to telehealth services among
22 rural communities in Illinois, the Department of Healthcare
23 and Family Services, ~~subject to appropriation,~~ shall
24 administer a program to provide at least \$10,000,000 in
25 financial support annually to critical access hospitals for
26 delivery of perinatal and OB/GYN services, behavioral

1 healthcare including SUDS, other specialty services and
2 telehealth services. The funding shall be used to preserve or
3 enhance perinatal and OB/GYN services, behavioral healthcare
4 including SUDS, other specialty services, as well as the
5 explanation of telehealth services by the receiving hospital,
6 with the distribution of funding to be established by rule.

7 (p) For calendar year 2023, the final amounts, rates, and
8 payments under subsections (c), (d-2), (g), (h), and (j) shall
9 be established by the Department, so that the sum of the total
10 estimated annual payments under subsections (c), (d-2), (g),
11 (h), and (j) for each hospital class for calendar year 2023, is
12 no less than:

13 (1) \$858,260,000 to safety-net hospitals.

14 (2) \$86,200,000 to critical access hospitals.

15 (3) \$1,765,000,000 to high Medicaid hospitals.

16 (4) \$673,860,000 to general acute care hospitals.

17 (5) \$48,330,000 to long term acute care hospitals.

18 (6) \$89,110,000 to freestanding psychiatric hospitals.

19 (7) \$24,300,000 to freestanding rehabilitation
20 hospitals.

21 (8) \$32,570,000 to public hospitals.

22 (q) Hospital Pandemic Recovery Stabilization Payments. The
23 Department shall disburse a pool of \$460,000,000 in stability
24 payments to hospitals prior to April 1, 2023. The allocation
25 of the pool shall be based on the hospital directed payment
26 classes and directed payments issued, during Calendar Year

1 2022 with added consideration to safety net hospitals, as
2 defined in subdivision (f)(1)(B) of this Section, and critical
3 access hospitals.

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

7 (305 ILCS 5/12-4.105)

8 Sec. 12-4.105. Human poison control center; payment
9 program. Subject to funding availability resulting from
10 transfers made from the Hospital Provider Fund to the
11 Healthcare Provider Relief Fund as authorized under this Code,
12 for State fiscal year 2017 and State fiscal year 2018, and for
13 each State fiscal year thereafter in which the assessment
14 under Section 5A-2 is imposed, the Department of Healthcare
15 and Family Services shall pay to the human poison control
16 center designated under the Poison Control System Act an
17 amount of not less than \$3,000,000 for each of State fiscal
18 years 2017 through 2020, and for State fiscal years 2021
19 through 2023 ~~2026~~ an amount of not less than \$3,750,000 and for
20 State fiscal years 2024 through 2026 an amount of not less than
21 \$4,000,000 and for the period July 1, 2026 through December
22 31, 2026 an amount of not less than \$2,000,000 ~~\$1,875,000~~, if
23 the human poison control center is in operation.

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

1 (305 ILCS 5/14-12)

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

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

10 (1) The Department shall establish Medicaid weighting
11 factors to be used in the reimbursement system established
12 under this subsection. Initial weighting factors shall be
13 the weighting factors as published by 3M Health
14 Information System, associated with Version 30.0 adjusted
15 for the Illinois experience.

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

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

26 (4) The Department shall develop add-on payments to

1 account for exceptionally costly inpatient stays,
2 consistent with Medicare outlier principles. Outlier fixed
3 loss thresholds may be updated to control for excessive
4 growth in outlier payments no more frequently than on an
5 annual basis, but at least once every 4 years. Upon
6 updating the fixed loss thresholds, the Department shall
7 be required to update base rates within 12 months.

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

14 (6) Beginning July 1, 2014 and ending on December 31,
15 2023 ~~June 30, 2024~~, in addition to the
16 statewide-standardized amount, the Department shall
17 develop an adjustor to adjust the rate of reimbursement
18 for safety-net hospitals defined in Section 5-5e.1 of this
19 Code excluding pediatric hospitals.

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

1 (7.5) (Blank).

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

9 (9) Beginning July 1, 2018, in addition to the
10 statewide-standardized amount, the Department shall apply
11 the same adjustor that is applied to trauma cases as of
12 December 31, 2017 to inpatient claims to treat patients
13 with burns, including, but not limited to, APR-DRGs 841,
14 842, 843, and 844.

15 (10) Beginning July 1, 2018, the
16 statewide-standardized amount for inpatient general acute
17 care services shall be uniformly increased so that base
18 claims projected reimbursement is increased by an amount
19 equal to the funds allocated in paragraph (1) of
20 subsection (b) of Section 5A-12.6, less the amount
21 allocated under paragraphs (8) and (9) of this subsection
22 and paragraphs (3) and (4) of subsection (b) multiplied by
23 40%.

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

1 (b) Outpatient hospital services. Effective for dates of
2 service on and after July 1, 2014, reimbursement for
3 outpatient services shall utilize the Enhanced Ambulatory
4 Procedure Grouping (EAPG) software, version 3.7 distributed by
5 3MTM Health Information System.

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

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

14 (A) The initial statewide standardized amounts,
15 with the labor portion adjusted by the Calendar Year
16 2013 Medicare Outpatient Prospective Payment System
17 wage index with reclassifications, shall be published
18 by the Department on its website no later than 10
19 calendar days prior to their effective date.

20 (B) The Department shall establish adjustments to
21 the statewide-standardized amounts for each Critical
22 Access Hospital, as designated by the Department of
23 Public Health in accordance with 42 CFR 485, Subpart
24 F. For outpatient services provided on or before June
25 30, 2018, the EAPG standardized amounts are determined
26 separately for each critical access hospital such that

1 simulated EAPG payments using outpatient base period
2 paid claim data plus payments under Section 5A-12.4 of
3 this Code net of the associated tax costs are equal to
4 the estimated costs of outpatient base period claims
5 data with a rate year cost inflation factor applied.

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

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

1 multiplied by the hospital's total acute cost to charge
2 ratio, less the claim line's EAPG payment plus \$1,000,
3 multiplied by 0.8.

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

12 (6) Effective for dates of service on or after July 1,
13 2018, the Department shall establish adjustments to the
14 statewide-standardized amounts for each Critical Access
15 Hospital, as designated by the Department of Public Health
16 in accordance with 42 CFR 485, Subpart F, such that each
17 Critical Access Hospital's standardized amount for
18 outpatient services shall be increased by the applicable
19 uniform percentage determined pursuant to paragraph (5) of
20 this subsection. It is the intent of the General Assembly
21 that the adjustments required under this paragraph (6) by
22 Public Act 100-1181 shall be applied retroactively to
23 claims for dates of service provided on or after July 1,
24 2018.

25 (7) Effective for dates of service on or after March
26 8, 2019 (the effective date of Public Act 100-1181), the

1 Department shall recalculate and implement an updated
2 statewide-standardized amount for outpatient services
3 provided by hospitals that are not Critical Access
4 Hospitals to reflect the applicable uniform percentage
5 determined pursuant to paragraph (5).

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

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

1 recalculation under this paragraph (7), issued to the
2 hospital for dates of service on or after July 1, 2018
3 and before March 8, 2019 (the effective date of Public
4 Act 100-1181), shall be permitted.

5 (8) The Department shall ensure that all necessary
6 adjustments to the managed care organization capitation
7 base rates necessitated by the adjustments under
8 subparagraph (6) or (7) of this subsection are completed
9 and applied retroactively in accordance with Section
10 5-30.8 of this Code within 90 days of March 8, 2019 (the
11 effective date of Public Act 100-1181).

12 (9) Within 60 days after federal approval of the
13 change made to the assessment in Section 5A-2 by Public
14 Act 101-650 ~~this amendatory Act of the 101st General~~
15 ~~Assembly~~, the Department shall incorporate into the EAPG
16 system for outpatient services those services performed by
17 hospitals currently billed through the Non-Institutional
18 Provider billing system.

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

25 (c) In consultation with the hospital community, the
26 Department is authorized to replace 89 Ill. Adm. Admin. Code

1 152.150 as published in 38 Ill. Reg. 4980 through 4986 within
2 12 months of June 16, 2014 (the effective date of Public Act
3 98-651). If the Department does not replace these rules within
4 12 months of June 16, 2014 (the effective date of Public Act
5 98-651), the rules in effect for 152.150 as published in 38
6 Ill. Reg. 4980 through 4986 shall remain in effect until
7 modified by rule by the Department. Nothing in this subsection
8 shall be construed to mandate that the Department file a
9 replacement rule.

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

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

25 (2) After the transition period, if the Department
26 reduces payments from the transitional hospital access

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

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

15 (1) Phase 1. In State fiscal years 2019 through 2020,
16 the Department shall allocate funds from the transitional
17 access hospital pool to create a hospital transformation
18 pool of at least \$262,906,870 annually and make hospital
19 transformation payments to hospitals. Subject to Section
20 5A-16, in State fiscal years 2019 and 2020, an Illinois
21 hospital that received either a transitional hospital
22 access payment under subsection (d) or a supplemental
23 payment under subsection (f) of this Section in State
24 fiscal year 2018, shall receive a hospital transformation
25 payment as follows:

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

1 inpatient utilization rate is equal to or greater than
2 45%, the hospital transformation payment shall be
3 equal to 100% of the sum of its transitional hospital
4 access payment authorized under subsection (d) and any
5 supplemental payment authorized under subsection (f).

6 (B) If the hospital's Rate Year 2017 Medicaid
7 inpatient utilization rate is equal to or greater than
8 25% but less than 45%, the hospital transformation
9 payment shall be equal to 75% of the sum of its
10 transitional hospital access payment authorized under
11 subsection (d) and any supplemental payment authorized
12 under subsection (f).

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

19 (2) Phase 2.

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

23 (B) Because there are communities in Illinois that
24 experience significant health care disparities due to
25 systemic racism, as recently emphasized by the
26 COVID-19 pandemic, aggravated by social determinants

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

1 in accordance with the transformation program shall be
2 considered purchases of care under the Illinois
3 Procurement Code, and funds shall be expended by the
4 Department in a manner that maximizes federal funding
5 to expend the entire allocated amount.

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

22 (C) As provided in paragraph (9) of Section 3 of
23 the Illinois Health Facilities Planning Act, any
24 hospital participating in the transformation program
25 may be excluded from the requirements of the Illinois
26 Health Facilities Planning Act for those projects

1 related to the hospital's transformation. To be
2 eligible, the hospital must submit to the Health
3 Facilities and Services Review Board approval from the
4 Department that the project is a part of the
5 hospital's transformation.

6 (D) As provided in subsection (a-20) of Section
7 32.5 of the Emergency Medical Services (EMS) Systems
8 Act, a hospital that received hospital transformation
9 payments under this Section may convert to a
10 freestanding emergency center. To be eligible for such
11 a conversion, the hospital must submit to the
12 Department of Public Health approval from the
13 Department that the project is a part of the
14 hospital's transformation.

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

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

22 (ii) the proposal shall be a collaboration
23 among providers across the care and community
24 spectrum, including preventative care, primary
25 care specialty care, hospital services, mental
26 health and substance abuse services, as well as

1 community-based entities that address the social
2 determinants of health;

3 (iii) the proposal shall be specifically
4 designed to improve healthcare outcomes and reduce
5 healthcare disparities, and improve the
6 coordination, effectiveness, and efficiency of
7 care delivery;

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

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

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

18 (F) Entities eligible to be funded.

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

26 (ii) The Department shall prioritize

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

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

1 to projects that are a collaboration between
2 hospitals and other providers in distressed areas
3 of the State designed to address specific
4 healthcare disparities, \$15,000,000 to
5 collaborations between critical access hospitals
6 and other providers designed to address specific
7 healthcare disparities, and \$15,000,000 to
8 cross-provider collaborations designed to address
9 specific healthcare disparities, and \$5,000,000 to
10 collaborations that focus on workforce
11 development.

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

26 (v) The Department shall take steps to ensure

1 that safety-net hospitals operating in
2 under-resourced communities receive priority
3 access to hospital and healthcare transformation
4 funds, including consulting funds, as provided
5 under this Section.

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

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

22 (ii) A detailed description of the racial and
23 ethnic makeup of the entities' board and
24 leadership positions and the salaries of the
25 executive staff of entities in the partnership
26 that is seeking to obtain funding under this

1 Section.

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

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

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

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

1 progress.

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

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

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

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

22 (xi) Verifiable project milestones and quality
23 metrics that will be impacted by transformation.
24 These project milestones and quality metrics must
25 be identified with improvement targets that must
26 be met.

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

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

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

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

19 (H) The Department shall evaluate proposals for
20 compliance with the criteria listed under subparagraph
21 (G). Proposals meeting all of the criteria may be
22 eligible for funding with the areas of focus
23 prioritized as described in item (ii) of subparagraph
24 (F). Based on the funds available, the Department may
25 negotiate funding agreements with approved applicants
26 to maximize federal funding. Nothing in this

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

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

14 (3) (Blank).

15 (4) Hospital Transformation Review Committee. There is
16 created the Hospital Transformation Review Committee. The
17 Committee shall consist of 14 members. No later than 30
18 days after March 12, 2018 (the effective date of Public
19 Act 100-581), the 4 legislative leaders shall each appoint
20 3 members; the Governor shall appoint the Director of
21 Healthcare and Family Services, or his or her designee, as
22 a member; and the Director of Healthcare and Family
23 Services shall appoint one member. Any vacancy shall be
24 filled by the applicable appointing authority within 15
25 calendar days. The members of the Committee shall select a
26 Chair and a Vice-Chair from among its members, provided

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

1 Committee is dissolved on April 1, 2019.

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

9 (f) Continuation of supplemental payments. Any
10 supplemental payments authorized under Illinois Administrative
11 Code 148 effective January 1, 2014 and that continue during
12 the period of July 1, 2014 through December 31, 2014 shall
13 remain in effect as long as the assessment imposed by Section
14 5A-2 that is in effect on December 31, 2017 remains in effect.

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

1 spending may be impacted by factors, including, but not
2 limited to, the number of individuals in the medical
3 assistance program and the severity of illness of the
4 individuals.

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

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

25 (j) Out-of-state hospitals. Beginning July 1, 2018, for
26 purposes of determining for State fiscal years 2019 and 2020

1 and subsequent fiscal years the hospitals eligible for the
2 payments authorized under subsections (a) and (b) of this
3 Section, the Department shall include out-of-state hospitals
4 that are designated a Level I pediatric trauma center or a
5 Level I trauma center by the Department of Public Health as of
6 December 1, 2017.

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

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

12 (Source: P.A. 101-81, eff. 7-12-19; 101-650, eff. 7-7-20;
13 101-655, eff. 3-12-21; 102-682, eff. 12-10-21; 102-1037, eff.
14 6-2-22; revised 8-22-22.)

15 (305 ILCS 5/14-12.5 new)

16 Sec. 14-12.5. Hospital rate updates.

17 (a) Notwithstanding any other provision of this Code, the
18 hospital rates of reimbursement authorized under Sections
19 5-5.05, 14-12, and 14-13 of this Code shall be adjusted in
20 accordance with the provisions of this Section.

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

25 (1) For inpatient general acute care services, the

1 statewide-standardized amount and the per diem rates for
2 hospitals exempt from the APR-DRG reimbursement system, in
3 effect January 1, 2023, shall be increased by 10%.

4 (2) For inpatient psychiatric services:

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

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

24 (C) For all psychiatric specialty hospitals, the
25 per diem rates in effect January 1, 2023, shall be
26 increased by 10%, except that all rates shall be at

1 least 90% of the minimum inpatient per diem rate for
2 safety-net hospitals as authorized in subsection (b-5)
3 of Section 5-5.05 of this Code, including the
4 adjustments authorized in this Section. The statewide
5 default per diem rate for a new psychiatric specialty
6 hospital shall be set at 90% of the minimum inpatient
7 psychiatric care per diem rate for safety-net
8 hospitals as authorized in subsection (b-5) of Section
9 5-5.05 of this Code, including the adjustment
10 authorized in this Section.

11 (3) For inpatient rehabilitative services, all
12 hospital specific per diem rates in effect January 1,
13 2023, shall be increased by 10%. The statewide default
14 inpatient rehabilitative services per diem rates, for
15 general acute care hospitals and for rehabilitation
16 specialty hospitals respectively, shall be increased by
17 10%.

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

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

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

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

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

11 (A) For Psychiatric days of care, the Department
12 may implement payment of this add-on by increasing the
13 hospital specific psychiatric per diem rate, adjusted
14 in accordance with subparagraph (A) of paragraph (2)
15 of subsection (b) by \$210, or by a separate add-on
16 payment.

17 (B) If the add-on adjustment is added to the
18 hospital specific psychiatric per diem rate to
19 operationalize payment, the Department shall provide a
20 rate sheet to each safety-net hospital, which
21 identifies the hospital psychiatric per diem rate
22 before and after the adjustment.

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

26 (c) The Department shall take all actions necessary to

1 ensure the changes authorized in this amendatory Act of the
2 103rd General Assembly are in effect for dates of service on
3 and after January 1, 2024, including publishing all
4 appropriate public notices, applying for federal approval of
5 amendments to the Illinois Title XIX State Plan, and adopting
6 administrative rules if necessary.

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

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

25 (f) The Department shall publish updated rate sheets for
26 all hospitals 30 days prior to the effective date of the rate

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

4 (305 ILCS 5/14-12.7 new)

5 Sec. 14-12.7. Public critical access hospital
6 stabilization program.

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

17 (b) The funding allocation methodology shall provide added
18 consideration to the services provided by qualifying hospitals
19 designated by the Department of Public Health as a perinatal
20 center.

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

24 (d) As used in this Section, "public critical access
25 hospital" means a hospital designated by the Department of

1 Public Health as a critical access hospital and that is owned
2 or operated by an Illinois Government body or municipality.

3 ARTICLE 15.

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

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

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

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

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

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

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

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

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

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

24 Upon receipt of federal approval of an amendment to the
25 Illinois Title XIX State Plan for this purpose, the Department
26 shall authorize the Chicago Public Schools (CPS) to procure a

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

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

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

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

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

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

22 Notwithstanding any other provision of this Code and
23 subject to federal approval, the Department may adopt rules to
24 allow a dentist who is volunteering his or her service at no
25 cost to render dental services through an enrolled
26 not-for-profit health clinic without the dentist personally

1 enrolling as a participating provider in the medical
2 assistance program. A not-for-profit health clinic shall
3 include a public health clinic or Federally Qualified Health
4 Center or other enrolled provider, as determined by the
5 Department, through which dental services covered under this
6 Section are performed. The Department shall establish a
7 process for payment of claims for reimbursement for covered
8 dental services rendered under this provision.

9 On and after January 1, 2022, the Department of Healthcare
10 and Family Services shall administer and regulate a
11 school-based dental program that allows for the out-of-office
12 delivery of preventative dental services in a school setting
13 to children under 19 years of age. The Department shall
14 establish, by rule, guidelines for participation by providers
15 and set requirements for follow-up referral care based on the
16 requirements established in the Dental Office Reference Manual
17 published by the Department that establishes the requirements
18 for dentists participating in the All Kids Dental School
19 Program. Every effort shall be made by the Department when
20 developing the program requirements to consider the different
21 geographic differences of both urban and rural areas of the
22 State for initial treatment and necessary follow-up care. No
23 provider shall be charged a fee by any unit of local government
24 to participate in the school-based dental program administered
25 by the Department. Nothing in this paragraph shall be
26 construed to limit or preempt a home rule unit's or school

1 district's authority to establish, change, or administer a
2 school-based dental program in addition to, or independent of,
3 the school-based dental program administered by the
4 Department.

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

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

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

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

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

25 (C) A mammogram at the age and intervals considered
26 medically necessary by the individual's health care

1 provider for individuals under 40 years of age and having
2 a family history of breast cancer, prior personal history
3 of breast cancer, positive genetic testing, or other risk
4 factors.

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

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

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

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

25 All screenings shall include a physical breast exam,
26 instruction on self-examination and information regarding the

1 frequency of self-examination and its value as a preventative
2 tool.

3 For purposes of this Section:

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

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

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

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

22 If, at any time, the Secretary of the United States
23 Department of Health and Human Services, or its successor
24 agency, promulgates rules or regulations to be published in
25 the Federal Register or publishes a comment in the Federal
26 Register or issues an opinion, guidance, or other action that

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

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

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

25 The Department shall convene an expert panel including
26 representatives of hospitals, free-standing mammography

1 facilities, and doctors, including radiologists, to establish
2 quality standards for mammography.

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

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

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

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

1 cancer outreach and patient navigation to optimize these
2 reminders and shall establish a methodology for evaluating
3 their effectiveness and modifying the methodology based on the
4 evaluation.

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

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

25 The Department shall require all networks of care to
26 develop a means either internally or by contract with experts

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

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

15 On or after July 1, 2022, individuals who are otherwise
16 eligible for medical assistance under this Article shall
17 receive coverage for perinatal depression screenings for the
18 12-month period beginning on the last day of their pregnancy.
19 Medical assistance coverage under this paragraph shall be
20 conditioned on the use of a screening instrument approved by
21 the Department.

22 Any medical or health care provider shall immediately
23 recommend, to any pregnant individual who is being provided
24 prenatal services and is suspected of having a substance use
25 disorder as defined in the Substance Use Disorder Act,
26 referral to a local substance use disorder treatment program

1 licensed by the Department of Human Services or to a licensed
2 hospital which provides substance abuse treatment services.
3 The Department of Healthcare and Family Services shall assure
4 coverage for the cost of treatment of the drug abuse or
5 addiction for pregnant recipients in accordance with the
6 Illinois Medicaid Program in conjunction with the Department
7 of Human Services.

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

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

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

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

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

20 The sponsor must negotiate formal written contracts with
21 medical providers for physician services, inpatient and
22 outpatient hospital care, home health services, treatment for
23 alcoholism and substance abuse, and other services determined
24 necessary by the Illinois Department by rule for delivery by
25 Partnerships. Physician services must include prenatal and
26 obstetrical care. The Illinois Department shall reimburse

1 medical services delivered by Partnership providers to clients
2 in target areas according to provisions of this Article and
3 the Illinois Health Finance Reform Act, except that:

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

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

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

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

25 Nothing in this Section shall limit the free choice of
26 practitioners, hospitals, and other providers of medical

1 services by clients. In order to ensure patient freedom of
2 choice, the Illinois Department shall immediately promulgate
3 all rules and take all other necessary actions so that
4 provided services may be accessed from therapeutically
5 certified optometrists to the full extent of the Illinois
6 Optometric Practice Act of 1987 without discriminating between
7 service providers.

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

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

1 accurately document the nature, scope, details and receipt of
2 the health care provided to persons eligible for medical
3 assistance under this Code, in accordance with regulations
4 promulgated by the Illinois Department. The rules and
5 regulations shall require that proof of the receipt of
6 prescription drugs, dentures, prosthetic devices and
7 eyeglasses by eligible persons under this Section accompany
8 each claim for reimbursement submitted by the dispenser of
9 such medical services. No such claims for reimbursement shall
10 be approved for payment by the Illinois Department without
11 such proof of receipt, unless the Illinois Department shall
12 have put into effect and shall be operating a system of
13 post-payment audit and review which shall, on a sampling
14 basis, be deemed adequate by the Illinois Department to assure
15 that such drugs, dentures, prosthetic devices and eyeglasses
16 for which payment is being made are actually being received by
17 eligible recipients. Within 90 days after September 16, 1984
18 (the effective date of Public Act 83-1439), the Illinois
19 Department shall establish a current list of acquisition costs
20 for all prosthetic devices and any other items recognized as
21 medical equipment and supplies reimbursable under this Article
22 and shall update such list on a quarterly basis, except that
23 the acquisition costs of all prescription drugs shall be
24 updated no less frequently than every 30 days as required by
25 Section 5-5.12.

26 Notwithstanding any other law to the contrary, the

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

11 Notwithstanding any other law to the contrary, the
12 Illinois Department shall, within 365 days after August 15,
13 2014 (the effective date of Public Act 98-963), establish
14 procedures to permit ID/DD facilities licensed under the ID/DD
15 Community Care Act and MC/DD facilities licensed under the
16 MC/DD Act to submit monthly billing claims for reimbursement
17 purposes. Following development of these procedures, the
18 Department shall have an additional 365 days to test the
19 viability of the new system and to ensure that any necessary
20 operational or structural changes to its information
21 technology platforms are implemented.

22 The Illinois Department shall require all dispensers of
23 medical services, other than an individual practitioner or
24 group of practitioners, desiring to participate in the Medical
25 Assistance program established under this Article to disclose
26 all financial, beneficial, ownership, equity, surety or other

1 interests in any and all firms, corporations, partnerships,
2 associations, business enterprises, joint ventures, agencies,
3 institutions or other legal entities providing any form of
4 health care services in this State under this Article.

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

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

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

25 Prior to enrollment and during the conditional enrollment
26 period in the medical assistance program, all vendors shall be

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

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

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

1 exceptions:

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

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

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

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

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

25 In the case of long term care facilities, within 120
26 calendar days of receipt by the facility of required

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

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

18 To the extent consistent with applicable information and
19 privacy, security, and disclosure laws, State and federal
20 agencies and departments shall provide the Illinois Department
21 access to confidential and other information and data
22 necessary to perform eligibility and payment verifications and
23 other Illinois Department functions. This includes, but is not
24 limited to: information pertaining to licensure;
25 certification; earnings; immigration status; citizenship; wage
26 reporting; unearned and earned income; pension income;

1 employment; supplemental security income; social security
2 numbers; National Provider Identifier (NPI) numbers; the
3 National Practitioner Data Bank (NPDB); program and agency
4 exclusions; taxpayer identification numbers; tax delinquency;
5 corporate information; and death records.

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

23 Beginning in fiscal year 2013, the Illinois Department
24 shall set forth a request for information to identify the
25 benefits of a pre-payment, post-adjudication, and post-edit
26 claims system with the goals of streamlining claims processing

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

11 The Illinois Department shall establish policies,
12 procedures, standards and criteria by rule for the
13 acquisition, repair and replacement of orthotic and prosthetic
14 devices and durable medical equipment. Such rules shall
15 provide, but not be limited to, the following services: (1)
16 immediate repair or replacement of such devices by recipients;
17 and (2) rental, lease, purchase or lease-purchase of durable
18 medical equipment in a cost-effective manner, taking into
19 consideration the recipient's medical prognosis, the extent of
20 the recipient's needs, and the requirements and costs for
21 maintaining such equipment. Subject to prior approval, such
22 rules shall enable a recipient to temporarily acquire and use
23 alternative or substitute devices or equipment pending repairs
24 or replacements of any device or equipment previously
25 authorized for such recipient by the Department.
26 Notwithstanding any provision of Section 5-5f to the contrary,

1 the Department may, by rule, exempt certain replacement
2 wheelchair parts from prior approval and, for wheelchairs,
3 wheelchair parts, wheelchair accessories, and related seating
4 and positioning items, determine the wholesale price by
5 methods other than actual acquisition costs.

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

14 In order to promote environmental responsibility, meet the
15 needs of recipients and enrollees, and achieve significant
16 cost savings, the Department, or a managed care organization
17 under contract with the Department, may provide recipients or
18 managed care enrollees who have a prescription or Certificate
19 of Medical Necessity access to refurbished durable medical
20 equipment under this Section (excluding prosthetic and
21 orthotic devices as defined in the Orthotics, Prosthetics, and
22 Pedorthics Practice Act and complex rehabilitation technology
23 products and associated services) through the State's
24 assistive technology program's reutilization program, using
25 staff with the Assistive Technology Professional (ATP)
26 Certification if the refurbished durable medical equipment:

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

17 The Department shall execute, relative to the nursing home
18 prescreening project, written inter-agency agreements with the
19 Department of Human Services and the Department on Aging, to
20 effect the following: (i) intake procedures and common
21 eligibility criteria for those persons who are receiving
22 non-institutional services; and (ii) the establishment and
23 development of non-institutional services in areas of the
24 State where they are not currently available or are
25 undeveloped; and (iii) notwithstanding any other provision of
26 law, subject to federal approval, on and after July 1, 2012, an

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

22 The Illinois Department shall develop and operate, in
23 cooperation with other State Departments and agencies and in
24 compliance with applicable federal laws and regulations,
25 appropriate and effective systems of health care evaluation
26 and programs for monitoring of utilization of health care

1 services and facilities, as it affects persons eligible for
2 medical assistance under this Code.

3 The Illinois Department shall report annually to the
4 General Assembly, no later than the second Friday in April of
5 1979 and each year thereafter, in regard to:

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

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

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

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

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

24 Rulemaking authority to implement Public Act 95-1045, if
25 any, is conditioned on the rules being adopted in accordance
26 with all provisions of the Illinois Administrative Procedure

1 Act and all rules and procedures of the Joint Committee on
2 Administrative Rules; any purported rule not so adopted, for
3 whatever reason, is unauthorized.

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

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

25 Notwithstanding any other provision of this Code to the
26 contrary, on or after July 1, 2015, all FDA approved forms of

1 medication assisted treatment prescribed for the treatment of
2 alcohol dependence or treatment of opioid dependence shall be
3 covered under both fee for service and managed care medical
4 assistance programs for persons who are otherwise eligible for
5 medical assistance under this Article and shall not be subject
6 to any (1) utilization control, other than those established
7 under the American Society of Addiction Medicine patient
8 placement criteria, (2) prior authorization mandate, or (3)
9 lifetime restriction limit mandate.

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

25 Upon federal approval, the Department shall provide
26 coverage and reimbursement for all drugs that are approved for

1 marketing by the federal Food and Drug Administration and that
2 are recommended by the federal Public Health Service or the
3 United States Centers for Disease Control and Prevention for
4 pre-exposure prophylaxis and related pre-exposure prophylaxis
5 services, including, but not limited to, HIV and sexually
6 transmitted infection screening, treatment for sexually
7 transmitted infections, medical monitoring, assorted labs, and
8 counseling to reduce the likelihood of HIV infection among
9 individuals who are not infected with HIV but who are at high
10 risk of HIV infection.

11 A federally qualified health center, as defined in Section
12 1905(1)(2)(B) of the federal Social Security Act, shall be
13 reimbursed by the Department in accordance with the federally
14 qualified health center's encounter rate for services provided
15 to medical assistance recipients that are performed by a
16 dental hygienist, as defined under the Illinois Dental
17 Practice Act, working under the general supervision of a
18 dentist and employed by a federally qualified health center.

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

26 Subject to approval by the federal Centers for Medicare

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

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

16 Notwithstanding any other provision of this Code, within
17 12 months after June 2, 2022 (the effective date of Public Act
18 102-1037) ~~this amendatory Act of the 102nd General Assembly~~
19 and subject to federal approval, acupuncture services
20 performed by an acupuncturist licensed under the Acupuncture
21 Practice Act who is acting within the scope of his or her
22 license shall be covered under the medical assistance program.
23 The Department shall apply for any federal waiver or State
24 Plan amendment, if required, to implement this paragraph. The
25 Department may adopt any rules, including standards and
26 criteria, necessary to implement this paragraph.

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 (Source: P.A. 101-10, eff. 6-5-19; 102-43, eff. 7-6-21;
3 102-699, eff. 4-19-22.)

4 ARTICLE 25.

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

7 (305 ILCS 5/12-4.57 new)

8 Sec. 12-4.57. Prospective Payment System rates; increase
9 for federally qualified health centers. Beginning January 1,
10 2024, subject to federal approval, the Department of
11 Healthcare and Family Services shall increase the Prospective
12 Payment System rates for federally qualified health centers to
13 a level calculated to spend an additional \$50,000,000 in the
14 first year of application using an alternative payment method
15 acceptable to the Centers for Medicare and Medicaid Services
16 and a trade association representing a majority of federally
17 qualified health centers operating in Illinois, including a
18 rate increase that is an equal percentage increase to the
19 rates paid to each federally qualified health center.

20 ARTICLE 30.

21 Section 30-5. The Specialized Mental Health Rehabilitation

1 Act of 2013 is amended by changing Section 5-107 as follows:

2 (210 ILCS 49/5-107)

3 Sec. 5-107. Quality of life enhancement. Beginning on July
4 1, 2019, for improving the quality of life and the quality of
5 care, an additional payment shall be awarded to a facility for
6 their single occupancy rooms. This payment shall be in
7 addition to the rate for recovery and rehabilitation. The
8 additional rate for single room occupancy shall be no less
9 than \$10 per day, per single room occupancy. The Department of
10 Healthcare and Family Services shall adjust payment to
11 Medicaid managed care entities to cover these costs. Beginning
12 July 1, 2022, for improving the quality of life and the quality
13 of care, a payment of no less than \$5 per day, per single room
14 occupancy shall be added to the existing \$10 additional per
15 day, per single room occupancy rate for a total of at least \$15
16 per day, per single room occupancy. For improving the quality
17 of life and the quality of care, on January 1, 2024, a payment
18 of no less than \$10.50 per day, per single room occupancy shall
19 be added to the existing \$15 additional per day, per single
20 room occupancy rate for a total of at least \$25.50 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

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

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

14 ARTICLE 35.

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

17 (305 ILCS 5/5-2b)

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

21 (a) Notwithstanding any other provision of law except as
22 provided in Section 5-30a, on and after September 1, 2012,
23 subject to federal approval, medical assistance under this

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

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

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

23 ARTICLE 40.

24 Section 40-5. The Illinois Public Aid Code is amended by

1 changing Section 5-5.2 as follows:

2 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

3 Sec. 5-5.2. Payment.

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

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

10 (c) (Blank).

11 (c-1) Notwithstanding any other provisions of this Code,
12 the methodologies for reimbursement of nursing services as
13 provided under this Article shall no longer be applicable for
14 bills payable for nursing services rendered on or after a new
15 reimbursement system based on the Patient Driven Payment Model
16 (PDPM) has been fully operationalized, which shall take effect
17 for services provided on or after the implementation of the
18 PDPM reimbursement system begins. For the purposes of this
19 amendatory Act of the 102nd General Assembly, the
20 implementation date of the PDPM reimbursement system and all
21 related provisions shall be July 1, 2022 if the following
22 conditions are met: (i) the Centers for Medicare and Medicaid
23 Services has approved corresponding changes in the
24 reimbursement system and bed assessment; and (ii) the
25 Department has filed rules to implement these changes no later

1 than June 1, 2022. Failure of the Department to file rules to
2 implement the changes provided in this amendatory Act of the
3 102nd General Assembly no later than June 1, 2022 shall result
4 in the implementation date being delayed to October 1, 2022.

5 (d) The new nursing services reimbursement methodology
6 utilizing the Patient Driven Payment Model, which shall be
7 referred to as the PDPM reimbursement system, taking effect
8 July 1, 2022, upon federal approval by the Centers for
9 Medicare and Medicaid Services, shall be based on the
10 following:

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

14 (2) Costs shall be annually rebased and case mix index
15 quarterly updated. The nursing services methodology will
16 be assigned to the Medicaid enrolled residents on record
17 as of 30 days prior to the beginning of the rate period in
18 the Department's Medicaid Management Information System
19 (MMIS) as present on the last day of the second quarter
20 preceding the rate period based upon the Assessment
21 Reference Date of the Minimum Data Set (MDS).

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

26 (4) PDPM nursing case mix indices in effect on March

1 1, 2022 shall be assigned to each resident class at no less
2 than 0.7858 of the Centers for Medicare and Medicaid
3 Services PDPM unadjusted case mix values, in effect on
4 March 1, 2022.

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

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

20 Facilities with at least 70% of the staffing indicated
21 by the STRIVE study shall be paid a per diem add-on of \$9,
22 increasing by equivalent steps for each whole percentage
23 point until the facilities reach a per diem of \$14.88.
24 Facilities with at least 80% of the staffing indicated by
25 the STRIVE study shall be paid a per diem add-on of \$14.88,
26 increasing by equivalent steps for each whole percentage

1 point until the facilities reach a per diem add-on of
2 \$23.80. Facilities with at least 92% of the staffing
3 indicated by the STRIVE study shall be paid a per diem
4 add-on of \$23.80, increasing by equivalent steps for each
5 whole percentage point until the facilities reach a per
6 diem add-on of \$29.75. Facilities with at least 100% of
7 the staffing indicated by the STRIVE study shall be paid a
8 per diem add-on of \$29.75, increasing by equivalent steps
9 for each whole percentage point until the facilities reach
10 a per diem add-on of \$35.70. Facilities with at least 110%
11 of the staffing indicated by the STRIVE study shall be
12 paid a per diem add-on of \$35.70, increasing by equivalent
13 steps for each whole percentage point until the facilities
14 reach a per diem add-on of \$38.68. Facilities with at
15 least 125% or higher of the staffing indicated by the
16 STRIVE study shall be paid a per diem add-on of \$38.68.
17 Beginning April 1, 2023, no nursing facility's variable
18 staffing per diem add-on shall be reduced by more than 5%
19 in 2 consecutive quarters. For the quarters beginning July
20 1, 2022 and October 1, 2022, no facility's variable per
21 diem staffing add-on shall be calculated at a rate lower
22 than 85% of the staffing indicated by the STRIVE study. No
23 facility below 70% of the staffing indicated by the STRIVE
24 study shall receive a variable per diem staffing add-on
25 after December 31, 2022.

26 (7) For dates of services beginning July 1, 2022, the

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

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

12 (B) for the quarter beginning October 1, 2022, the
13 sum of the RUG-IV nursing component per diem
14 multiplied by 0.80 and the PDPM nursing component per
15 diem multiplied by 0.20;

16 (C) for the quarter beginning January 1, 2023, the
17 sum of the RUG-IV nursing component per diem
18 multiplied by 0.60 and the PDPM nursing component per
19 diem multiplied by 0.40;

20 (D) for the quarter beginning April 1, 2023, the
21 sum of the RUG-IV nursing component per diem
22 multiplied by 0.40 and the PDPM nursing component per
23 diem multiplied by 0.60;

24 (E) for the quarter beginning July 1, 2023, the
25 sum of the RUG-IV nursing component per diem
26 multiplied by 0.20 and the PDPM nursing component per

1 diem multiplied by 0.80; or

2 (F) for the quarter beginning October 1, 2023 and
3 each subsequent quarter, the transition rate shall end
4 and a nursing facility shall be paid 100% of the PDP
5 nursing component per diem.

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

8 (1) Base rate spending pool shall be:

9 (A) The base year resident days which are
10 calculated by multiplying the number of Medicaid
11 residents in each nursing home as indicated in the MDS
12 data defined in paragraph (4) by 365.

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

16 (C) Thirteen million is added to the product of
17 subparagraph (A) and subparagraph (B) to adjust for
18 the exclusion of nursing homes defined in paragraph
19 (5).

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

25 (A) Base year resident days as calculated in
26 subparagraph (A) of paragraph (1).

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

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

9 (D) The sum of the products calculated for each
10 nursing home in subparagraphs (A) through (C) above
11 shall be the base year case mix, rate adjusted
12 weighted days.

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

14 (A) on January 1, 2014 shall be the quotient of the
15 paragraph (1) divided by the sum calculated under
16 subparagraph (D) of paragraph (2);

17 (B) on and after July 1, 2014 and until July 1,
18 2022, shall be the amount calculated under
19 subparagraph (A) of this paragraph (3) plus \$1.76; and

20 (C) beginning July 1, 2022 and thereafter, \$7
21 shall be added to the amount calculated under
22 subparagraph (B) of this paragraph (3) of this
23 Section.

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

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

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

11 (1) \$0.63 for each resident who scores in I4200
12 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

13 (2) \$2.67 for each resident who scores either a "1" or
14 "2" in any items S1200A through S1200I and also scores in
15 RUG groups PA1, PA2, BA1, or BA2.

16 (e-1) (Blank).

17 (e-2) For dates of services beginning January 1, 2014 and
18 ending September 30, 2023, the RUG-IV nursing component per
19 diem for a nursing home shall be the product of the statewide
20 RUG-IV nursing base per diem rate, the facility average case
21 mix index, and the regional wage adjustor. For dates of
22 service beginning July 1, 2022 and ending September 30, 2023,
23 the Medicaid access adjustment described in subsection (e-3)
24 shall be added to the product.

25 (e-3) A Medicaid Access Adjustment of \$4 adjusted for the
26 facility average PDPM case mix index calculated quarterly

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

10 (f) (Blank).

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

16 (1) (Blank);

17 (2) (Blank);

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

20 (h) Notwithstanding any other provision of this Code, on
21 and after July 1, 2012, nursing facilities designated by the
22 Department of Healthcare and Family Services as "Institutions
23 for Mental Disease" and "Institutions for Mental Disease" that
24 are facilities licensed under the Specialized Mental Health
25 Rehabilitation Act of 2013 shall have the nursing,
26 socio-developmental, capital, and support components of their

1 reimbursement rate effective May 1, 2011 reduced in total by
2 2.7%.

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

8 (i-1) Subject to federal approval, on and after January 1,
9 2024, the reimbursement rates for the support component of the
10 nursing facility rate for facilities licensed under the
11 Nursing Home Care Act as skilled or intermediate care
12 facilities shall be the rate in effect on June 30, 2023
13 increased by 12%.

14 (j) Notwithstanding any other provision of law, subject to
15 federal approval, effective July 1, 2019, sufficient funds
16 shall be allocated for changes to rates for facilities
17 licensed under the Nursing Home Care Act as skilled nursing
18 facilities or intermediate care facilities for dates of
19 services on and after July 1, 2019: (i) to establish, through
20 June 30, 2022 a per diem add-on to the direct care per diem
21 rate not to exceed \$70,000,000 annually in the aggregate
22 taking into account federal matching funds for the purpose of
23 addressing the facility's unique staffing needs, adjusted
24 quarterly and distributed by a weighted formula based on
25 Medicaid bed days on the last day of the second quarter
26 preceding the quarter for which the rate is being adjusted.

1 Beginning July 1, 2022, the annual \$70,000,000 described in
2 the preceding sentence shall be dedicated to the variable per
3 diem add-on for staffing under paragraph (6) of subsection
4 (d); and (ii) in an amount not to exceed \$170,000,000 annually
5 in the aggregate taking into account federal matching funds to
6 permit the support component of the nursing facility rate to
7 be updated as follows:

8 (1) 80%, or \$136,000,000, of the funds shall be used
9 to update each facility's rate in effect on June 30, 2019
10 using the most recent cost reports on file, which have had
11 a limited review conducted by the Department of Healthcare
12 and Family Services and will not hold up enacting the rate
13 increase, with the Department of Healthcare and Family
14 Services.

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

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

23 (k) During the first quarter of State Fiscal Year 2020,
24 the Department of Healthcare of Family Services must convene a
25 technical advisory group consisting of members of all trade
26 associations representing Illinois skilled nursing providers

1 to discuss changes necessary with federal implementation of
2 Medicare's Patient-Driven Payment Model. Implementation of
3 Medicare's Patient-Driven Payment Model shall, by September 1,
4 2020, end the collection of the MDS data that is necessary to
5 maintain the current RUG-IV Medicaid payment methodology. The
6 technical advisory group must consider a revised reimbursement
7 methodology that takes into account transparency,
8 accountability, actual staffing as reported under the
9 federally required Payroll Based Journal system, changes to
10 the minimum wage, adequacy in coverage of the cost of care, and
11 a quality component that rewards quality improvements.

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

15 (1) Incentive payments determined by facility
16 performance on specified quality measures in an initial
17 amount of \$70,000,000. Nothing in this subsection shall be
18 construed to limit the quality of care payments in the
19 aggregate statewide to \$70,000,000, and, if quality of
20 care has improved across nursing facilities, the
21 Department shall adjust those add-on payments accordingly.
22 The quality payment methodology described in this
23 subsection must be used for at least State Fiscal Year
24 2023. Beginning with the quarter starting July 1, 2023,
25 the Department may add, remove, or change quality metrics
26 and make associated changes to the quality payment

1 methodology as outlined in subparagraph (E). Facilities
2 designated by the Centers for Medicare and Medicaid
3 Services as a special focus facility or a hospital-based
4 nursing home do not qualify for quality payments.

5 (A) Each quality pool must be distributed by
6 assigning a quality weighted score for each nursing
7 home which is calculated by multiplying the nursing
8 home's quality base period Medicaid days by the
9 nursing home's star rating weight in that period.

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

18 (i) Zero-star or one-star rating has a weight
19 of 0.

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

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

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

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

24 (C) Each nursing home's quality weight score is
25 divided by the sum of all quality weight scores for
26 qualifying nursing homes to determine the proportion

1 of the quality pool to be paid to the nursing home.

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

16 (E) The Department shall review quality metrics
17 used for payment of the quality pool and make
18 recommendations for any associated changes to the
19 methodology for distributing quality pool payments in
20 consultation with associations representing long-term
21 care providers, consumer advocates, organizations
22 representing workers of long-term care facilities, and
23 payors. The Department may establish, by rule, changes
24 to the methodology for distributing quality pool
25 payments.

26 (F) The Department shall disburse quality pool

1 payments from the Long-Term Care Provider Fund on a
2 monthly basis in amounts proportional to the total
3 quality pool payment determined for the quarter.

4 (G) The Department shall publish any changes in
5 the methodology for distributing quality pool payments
6 prior to the beginning of the measurement period or
7 quality base period for any metric added to the
8 distribution's methodology.

9 (2) Payments based on CNA tenure, promotion, and CNA
10 training for the purpose of increasing CNA compensation.
11 It is the intent of this subsection that payments made in
12 accordance with this paragraph be directly incorporated
13 into increased compensation for CNAs. As used in this
14 paragraph, "CNA" means a certified nursing assistant as
15 that term is described in Section 3-206 of the Nursing
16 Home Care Act, Section 3-206 of the ID/DD Community Care
17 Act, and Section 3-206 of the MC/DD Act. The Department
18 shall establish, by rule, payments to nursing facilities
19 equal to Medicaid's share of the tenure wage increments
20 specified in this paragraph for all reported CNA employee
21 hours compensated according to a posted schedule
22 consisting of increments at least as large as those
23 specified in this paragraph. The increments are as
24 follows: an additional \$1.50 per hour for CNAs with at
25 least one and less than 2 years' experience plus another
26 \$1 per hour for each additional year of experience up to a

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

19 (m) The Department shall work with nursing facility
20 industry representatives to design policies and procedures to
21 permit facilities to address the integrity of data from
22 federal reporting sites used by the Department in setting
23 facility rates.

24 (Source: P.A. 101-10, eff. 6-5-19; 101-348, eff. 8-9-19;
25 102-77, eff. 7-9-21; 102-558, eff. 8-20-21; 102-1035, eff.
26 5-31-22; 102-1118, eff. 1-18-23.)

1 ARTICLE 45.

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

4 (20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

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

16 (a) (blank);

17 (b) (blank);

18 (c) home care aide services;

19 (d) personal assistant services;

20 (e) adult day services;

21 (f) home-delivered meals;

22 (g) education in self-care;

23 (h) personal care services;

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

13 The Department shall establish eligibility standards for

14 such services. In determining the amount and nature of

15 services for which a person may qualify, consideration shall

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

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

18 agreement dividing marital property into equal but separate

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

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

21 marital property is not made available to the person seeking

22 such services.

23 Beginning January 1, 2008, the Department shall require as

24 a condition of eligibility that all new financially eligible

25 applicants apply for and enroll in medical assistance under

26 Article V of the Illinois Public Aid Code in accordance with

1 rules promulgated by the Department.

2 The Department shall, in conjunction with the Department
3 of Public Aid (now Department of Healthcare and Family
4 Services), seek appropriate amendments under Sections 1915 and
5 1924 of the Social Security Act. The purpose of the amendments
6 shall be to extend eligibility for home and community based
7 services under Sections 1915 and 1924 of the Social Security
8 Act to persons who transfer to or for the benefit of a spouse
9 those amounts of income and resources allowed under Section
10 1924 of the Social Security Act. Subject to the approval of
11 such amendments, the Department shall extend the provisions of
12 Section 5-4 of the Illinois Public Aid Code to persons who, but
13 for the provision of home or community-based services, would
14 require the level of care provided in an institution, as is
15 provided for in federal law. Those persons no longer found to
16 be eligible for receiving noninstitutional services due to
17 changes in the eligibility criteria shall be given 45 days
18 notice prior to actual termination. Those persons receiving
19 notice of termination may contact the Department and request
20 the determination be appealed at any time during the 45 day
21 notice period. The target population identified for the
22 purposes of this Section are persons age 60 and older with an
23 identified service need. Priority shall be given to those who
24 are at imminent risk of institutionalization. The services
25 shall be provided to eligible persons age 60 and older to the
26 extent that the cost of the services together with the other

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

1 development of non-institutional services in areas of the
2 State where they are not currently available or are
3 undeveloped. On and after July 1, 1996, all nursing home
4 prescreenings for individuals 60 years of age or older shall
5 be conducted by the Department.

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

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

22 The Department, or the Department's authorized
23 representative, may recover the amount of moneys expended for
24 services provided to or in behalf of a person under this
25 Section by a claim against the person's estate or against the
26 estate of the person's surviving spouse, but no recovery may

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

25 The Department shall increase the effectiveness of the
26 existing Community Care Program by:

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

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

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

15 (4) ensuring that the determination of need tool is
16 accurate in determining the participants' level of need;
17 to achieve this, the Department, in conjunction with the
18 Older Adult Services Advisory Committee, shall institute a
19 study of the relationship between the Determination of
20 Need scores, level of need, service cost maximums, and the
21 development and utilization of service plans no later than
22 May 1, 2008; findings and recommendations shall be
23 presented to the Governor and the General Assembly no
24 later than January 1, 2009; recommendations shall include
25 all needed changes to the service cost maximums schedule
26 and additional covered services;

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

4 (A) bathing;

5 (B) grooming;

6 (C) toileting;

7 (D) nail care;

8 (E) transferring;

9 (F) respiratory services;

10 (G) exercise; or

11 (H) positioning;

12 (6) ensuring that homemaker program vendors are not
13 restricted from hiring homemakers who are family members
14 of clients or recommended by clients; the Department may
15 not, by rule or policy, require homemakers who are family
16 members of clients or recommended by clients to accept
17 assignments in homes other than the client;

18 (7) ensuring that the State may access maximum federal
19 matching funds by seeking approval for the Centers for
20 Medicare and Medicaid Services for modifications to the
21 State's home and community based services waiver and
22 additional waiver opportunities, including applying for
23 enrollment in the Balance Incentive Payment Program by May
24 1, 2013, in order to maximize federal matching funds; this
25 shall include, but not be limited to, modification that
26 reflects all changes in the Community Care Program

1 services and all increases in the services cost maximum;

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

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

14 (10) working in conjunction with Care Coordination
15 Units, the Department of Healthcare and Family Services,
16 the Department of Human Services, Community Care Program
17 providers, and other stakeholders to make improvements to
18 the Medicaid claiming processes and the Medicaid
19 enrollment procedures or requirements as needed,
20 including, but not limited to, specific policy changes or
21 rules to improve the up-front enrollment of participants
22 in the Medicaid program and specific policy changes or
23 rules to insure more prompt submission of bills to the
24 federal government to secure maximum federal matching
25 dollars as promptly as possible; the Department on Aging
26 shall have at least 3 meetings with stakeholders by

1 January 1, 2014 in order to address these improvements;

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

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

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

15 By January 1, 2009 or as soon after the end of the Cash and
16 Counseling Demonstration Project as is practicable, the
17 Department may, based on its evaluation of the demonstration
18 project, promulgate rules concerning personal assistant
19 services, to include, but need not be limited to,
20 qualifications, employment screening, rights under fair labor
21 standards, training, fiduciary agent, and supervision
22 requirements. All applicants shall be subject to the
23 provisions of the Health Care Worker Background Check Act.

24 The Department shall develop procedures to enhance
25 availability of services on evenings, weekends, and on an
26 emergency basis to meet the respite needs of caregivers.

1 Procedures shall be developed to permit the utilization of
2 services in successive blocks of 24 hours up to the monthly
3 maximum established by the Department. Workers providing these
4 services shall be appropriately trained.

5 Beginning on the effective date of this amendatory Act of
6 1991, no person may perform chore/housekeeping and home care
7 aide services under a program authorized by this Section
8 unless that person has been issued a certificate of
9 pre-service to do so by his or her employing agency.
10 Information gathered to effect such certification shall
11 include (i) the person's name, (ii) the date the person was
12 hired by his or her current employer, and (iii) the training,
13 including dates and levels. Persons engaged in the program
14 authorized by this Section before the effective date of this
15 amendatory Act of 1991 shall be issued a certificate of all
16 pre- and in-service training from his or her employer upon
17 submitting the necessary information. The employing agency
18 shall be required to retain records of all staff pre- and
19 in-service training, and shall provide such records to the
20 Department upon request and upon termination of the employer's
21 contract with the Department. In addition, the employing
22 agency is responsible for the issuance of certifications of
23 in-service training completed to their employees.

24 The Department is required to develop a system to ensure
25 that persons working as home care aides and personal
26 assistants receive increases in their wages when the federal

1 minimum wage is increased by requiring vendors to certify that
2 they are meeting the federal minimum wage statute for home
3 care aides and personal assistants. An employer that cannot
4 ensure that the minimum wage increase is being given to home
5 care aides and personal assistants shall be denied any
6 increase in reimbursement costs.

7 The Community Care Program Advisory Committee is created
8 in the Department on Aging. The Director shall appoint
9 individuals to serve in the Committee, who shall serve at
10 their own expense. Members of the Committee must abide by all
11 applicable ethics laws. The Committee shall advise the
12 Department on issues related to the Department's program of
13 services to prevent unnecessary institutionalization. The
14 Committee shall meet on a bi-monthly basis and shall serve to
15 identify and advise the Department on present and potential
16 issues affecting the service delivery network, the program's
17 clients, and the Department and to recommend solution
18 strategies. Persons appointed to the Committee shall be
19 appointed on, but not limited to, their own and their agency's
20 experience with the program, geographic representation, and
21 willingness to serve. The Director shall appoint members to
22 the Committee to represent provider, advocacy, policy
23 research, and other constituencies committed to the delivery
24 of high quality home and community-based services to older
25 adults. Representatives shall be appointed to ensure
26 representation from community care providers including, but

1 not limited to, adult day service providers, homemaker
2 providers, case coordination and case management units,
3 emergency home response providers, statewide trade or labor
4 unions that represent home care aides and direct care staff,
5 area agencies on aging, adults over age 60, membership
6 organizations representing older adults, and other
7 organizational entities, providers of care, or individuals
8 with demonstrated interest and expertise in the field of home
9 and community care as determined by the Director.

10 Nominations may be presented from any agency or State
11 association with interest in the program. The Director, or his
12 or her designee, shall serve as the permanent co-chair of the
13 advisory committee. One other co-chair shall be nominated and
14 approved by the members of the committee on an annual basis.
15 Committee members' terms of appointment shall be for 4 years
16 with one-quarter of the appointees' terms expiring each year.
17 A member shall continue to serve until his or her replacement
18 is named. The Department shall fill vacancies that have a
19 remaining term of over one year, and this replacement shall
20 occur through the annual replacement of expiring terms. The
21 Director shall designate Department staff to provide technical
22 assistance and staff support to the committee. Department
23 representation shall not constitute membership of the
24 committee. All Committee papers, issues, recommendations,
25 reports, and meeting memoranda are advisory only. The
26 Director, or his or her designee, shall make a written report,

1 as requested by the Committee, regarding issues before the
2 Committee.

3 The Department on Aging and the Department of Human
4 Services shall cooperate in the development and submission of
5 an annual report on programs and services provided under this
6 Section. Such joint report shall be filed with the Governor
7 and the General Assembly on or before March 31 ~~September 30~~
8 each year.

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

15 Those persons previously found eligible for receiving
16 non-institutional services whose services were discontinued
17 under the Emergency Budget Act of Fiscal Year 1992, and who do
18 not meet the eligibility standards in effect on or after July
19 1, 1992, shall remain ineligible on and after July 1, 1992.
20 Those persons previously not required to cost-share and who
21 were required to cost-share effective March 1, 1992, shall
22 continue to meet cost-share requirements on and after July 1,
23 1992. Beginning July 1, 1992, all clients will be required to
24 meet eligibility, cost-share, and other requirements and will
25 have services discontinued or altered when they fail to meet
26 these requirements.

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

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

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

20 The Department shall delay Community Care Program services
21 until an applicant is determined eligible for medical
22 assistance under Article V of the Illinois Public Aid Code (i)
23 beginning August 1, 2013, if the Auditor General has reported
24 that the Department has failed to comply with the reporting
25 requirements of Section 2-27 of the Illinois State Auditing
26 Act; or (ii) beginning June 1, 2014, if the Auditor General has

1 reported that the Department has not undertaken the required
2 actions listed in the report required by subsection (a) of
3 Section 2-27 of the Illinois State Auditing Act.

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

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

16 The Department shall conduct a quarterly review of Care
17 Coordination Unit performance and adherence to service
18 guidelines. The quarterly review shall be reported to the
19 Speaker of the House of Representatives, the Minority Leader
20 of the House of Representatives, the President of the Senate,
21 and the Minority Leader of the Senate. The Department shall
22 collect and report longitudinal data on the performance of
23 each care coordination unit. Nothing in this paragraph shall
24 be construed to require the Department to identify specific
25 care coordination units.

26 In regard to community care providers, failure to comply

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

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

14 Within 30 days after July 6, 2017 (the effective date of
15 Public Act 100-23), rates shall be increased to \$18.29 per
16 hour, for the purpose of increasing, by at least \$.72 per hour,
17 the wages paid by those vendors to their employees who provide
18 homemaker services. The Department shall pay an enhanced rate
19 under the Community Care Program to those in-home service
20 provider agencies that offer health insurance coverage as a
21 benefit to their direct service worker employees consistent
22 with the mandates of Public Act 95-713. For State fiscal years
23 2018 and 2019, the enhanced rate shall be \$1.77 per hour. The
24 rate shall be adjusted using actuarial analysis based on the
25 cost of care, but shall not be set below \$1.77 per hour. The
26 Department shall adopt rules, including emergency rules under

1 subsections (y) and (bb) of Section 5-45 of the Illinois
2 Administrative Procedure Act, to implement the provisions of
3 this paragraph.

4 Subject to federal approval, on and after January 1, 2024,
5 rates for homemaker services shall be increased to \$28.07 to
6 sustain a minimum wage of \$17 per hour for direct service
7 workers. Rates in subsequent State fiscal years shall be no
8 lower than the rates put into effect upon federal approval.
9 Providers of in-home services shall be required to certify to
10 the Department that they remain in compliance with the
11 mandated wage increase for direct service workers. Fringe
12 benefits, including, but not limited to, paid time off and
13 payment for training, health insurance, travel, or
14 transportation, shall not be reduced in relation to the rate
15 increases described in this paragraph.

16 The General Assembly finds it necessary to authorize an
17 aggressive Medicaid enrollment initiative designed to maximize
18 federal Medicaid funding for the Community Care Program which
19 produces significant savings for the State of Illinois. The
20 Department on Aging shall establish and implement a Community
21 Care Program Medicaid Initiative. Under the Initiative, the
22 Department on Aging shall, at a minimum: (i) provide an
23 enhanced rate to adequately compensate care coordination units
24 to enroll eligible Community Care Program clients into
25 Medicaid; (ii) use recommendations from a stakeholder
26 committee on how best to implement the Initiative; and (iii)

1 establish requirements for State agencies to make enrollment
2 in the State's Medical Assistance program easier for seniors.

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

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

14 (2) One representative of the Department of Healthcare
15 and Family Services, appointed by the Director of
16 Healthcare and Family Services.

17 (3) One representative of the Department of Human
18 Services, appointed by the Secretary of Human Services.

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

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

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

26 (7) One individual from a statewide association

1 dedicated to Alzheimer's care, support, and research,
2 appointed by the Director of Aging.

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

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

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

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

14 (12) One member of the House of Representatives, who
15 shall serve as co-chairperson, appointed by the Speaker of
16 the House of Representatives.

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

20 (14) One individual appointed by a labor organization
21 representing frontline employees at the Department of
22 Human Services.

23 The Subcommittee shall provide oversight to the Community
24 Care Program Medicaid Initiative and shall meet quarterly. At
25 each Subcommittee meeting the Department on Aging shall
26 provide the following data sets to the Subcommittee: (A) the

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

24 The Department on Aging, with the involvement of the
25 Subcommittee, shall collaborate with the Department of Human
26 Services and the Department of Healthcare and Family Services

1 on how best to achieve the responsibilities of the Community
2 Care Program Medicaid Initiative.

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

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

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

24 The Community Care Program Medicaid Initiative shall cease
25 operation 5 years after the effective date of this amendatory
26 Act of the 100th General Assembly, after which the

1 Subcommittee shall dissolve.

2 (Source: P.A. 101-10, eff. 6-5-19; 102-1071, eff. 6-10-22.)

3 ARTICLE 50.

4 Section 50-5. The Illinois Public Aid Code is amended by
5 changing Section 5-5.2 as follows:

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

7 Sec. 5-5.2. Payment.

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

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

14 (c) (Blank).

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

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

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

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

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

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

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

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

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

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

26 Facilities with at least 70% of the staffing indicated

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

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

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

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

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

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

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

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

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

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

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

14 (1) Base rate spending pool shall be:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 (e-1) (Blank).

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

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

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

16 (e-4) Subject to federal approval, on and after January 1,
17 2024, the Department shall increase the rate add-on at
18 paragraph (7) subsection (a) under 89 Ill. Adm. Code 147.335
19 for ventilator services from \$208 per day to \$481 per day.
20 Payment is subject to the criteria and requirements under 89
21 Ill. Adm. Code 147.335.

22 (f) (Blank).

23 (g) Notwithstanding any other provision of this Code, on
24 and after July 1, 2012, for facilities not designated by the
25 Department of Healthcare and Family Services as "Institutions
26 for Mental Disease", rates effective May 1, 2011 shall be

1 adjusted as follows:

2 (1) (Blank);

3 (2) (Blank);

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

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

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

20 (j) Notwithstanding any other provision of law, subject to
21 federal approval, effective July 1, 2019, sufficient funds
22 shall be allocated for changes to rates for facilities
23 licensed under the Nursing Home Care Act as skilled nursing
24 facilities or intermediate care facilities for dates of
25 services on and after July 1, 2019: (i) to establish, through
26 June 30, 2022 a per diem add-on to the direct care per diem

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

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

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

26 (3) The remainder of the 20%, or \$34,000,000, shall be

1 used to increase each facility's rate by an equal
2 percentage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (m) The Department shall work with nursing facility
26 industry representatives to design policies and procedures to

1 permit facilities to address the integrity of data from
2 federal reporting sites used by the Department in setting
3 facility rates.

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

7 ARTICLE 55.

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

10 (305 ILCS 5/5-5i new)

11 Sec. 5-5i. Rate increase for speech, physical, and
12 occupational therapy services. Subject to federal approval,
13 beginning January 1, 2024, the Department shall increase
14 reimbursement rates for speech therapy services, physical
15 therapy services, and occupational therapy services provided
16 by licensed speech-language pathologists and speech-language
17 pathology assistants, physical therapists and physical therapy
18 assistants, and occupational therapists and certified
19 occupational therapy assistants, including those in their
20 clinical fellowship, by 14.2%.

21 ARTICLE 60.

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

3 (305 ILCS 5/5-35.5 new)

4 Sec. 5-35.5. Personal needs allowance; nursing home
5 residents. Subject to federal approval, on and after January
6 1, 2024, for a person who is a resident in a facility licensed
7 under the Nursing Home Care Act for whom payments are made
8 under this Article throughout a month and who is determined to
9 be eligible for medical assistance under this Article, the
10 monthly personal needs allowance shall be \$60.

11 ARTICLE 65.

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

15 (305 ILCS 66/20-10)

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

22 (a) The payment adjustments shall begin on July 1, 2022

1 for State Fiscal Year 2023 and shall continue for every State
2 fiscal year thereafter.

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

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

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

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

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

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

25 (5) Medicaid user-based directed payments.

26 (A) For each State fiscal year, a monthly directed

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

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

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

23 (B) For each State fiscal year, a monthly directed
24 payment shall be paid to each community mental health
25 provider of assertive community treatment services
26 based on the number of Medicaid users of assertive

1 community treatment services documented by Medicaid
2 fee-for-service and managed care encounter claims
3 delivered by the provider in the base year.

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

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

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

24 (b) Subject to federal approval, a one-time directed
25 payment must be made in calendar year 2023 for community
26 mental health services provided by community mental health

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

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

12 (1) Subject to federal approval, beginning on January
13 1, 2024, the Department shall introduce rate increases to
14 behavioral health services no less than by the following
15 targeted pool for the specified services provided by
16 community mental health centers:

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

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

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

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

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

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

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

25 (2) Rate increases shall be determined with
26 significant input from Illinois behavioral health trade

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

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

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

25 (2) In State Fiscal Year 2024, the Department shall
26 identify an existing, or establish a new, Behavioral

1 Health Outcomes Stakeholder Workgroup to help inform the
2 identification of metrics and outcomes for team-based
3 services.

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

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

11 (305 ILCS 66/20-20)

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

13 (a) For services under subsection (a) of Section 20-10: ~~7~~

14 No base Medicaid rate or Medicaid rate add-on payment or
15 any other payment for the provision of Medicaid community
16 mental health services in place on July 1, 2021 shall be
17 diminished or changed to make the reimbursement changes
18 required by this Act. Any payments required under this Act
19 that are delayed due to implementation challenges or federal
20 approval shall be made retroactive to July 1, 2022 for the full
21 amount required by this Act.

22 (b) For directed payments under subsection (b) of Section
23 20-10: ~~7~~

24 No base Medicaid rate payment or any other payment for the
25 provision of Medicaid community mental health services in

1 place on January 1, 2023 shall be diminished or changed to make
2 the reimbursement changes required by this Act. The Department
3 of Healthcare and Family Services must pay the directed
4 payment in one installment within 60 days of receiving federal
5 approval.

6 (c) For directed payments under subsection (c) of Section
7 20-10:

8 No base Medicaid rate payment or any other payment for the
9 provision of Medicaid community mental health services in
10 place on January 1, 2023 shall be diminished or changed to make
11 the reimbursement changes required by this amendatory Act of
12 the 103rd General Assembly. Any payments required under this
13 amendatory Act of the 103rd General Assembly that are delayed
14 due to implementation challenges or federal approval shall be
15 made retroactive to no later than January 1, 2024 for the full
16 amount required by this amendatory Act of the 103rd General
17 Assembly.

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

19 (305 ILCS 66/20-22 new)

20 Sec. 20-22. Implementation plan for cost reporting.

21 (a) For the purpose of understanding behavioral health
22 services cost structures and their impact on the Illinois
23 Medical Assistance Program, the Department shall engage
24 stakeholders to develop a plan for the regular collection of
25 cost reporting for all entity-based providers of behavioral

1 health services reimbursed under the Rehabilitation or
2 Prevention authorities of the Illinois Medicaid State Plan.
3 Data shall be used to inform on the effectiveness and
4 efficiency of Illinois Medicaid rates. The plan at minimum
5 should consider the following:

6 (1) alignment with certified community behavioral
7 health clinic requirements, standards, policies, and
8 procedures;

9 (2) inclusion of prospective costs to measure what is
10 needed to increase services and capacity;

11 (3) consideration of differences in collection and
12 policies based on the size of providers;

13 (4) consideration of additional administrative time
14 and costs;

15 (5) goals, purposes, and usage of data collected from
16 cost reports;

17 (6) inclusion of qualitative data in addition to
18 quantitative data;

19 (7) technical assistance for providers for completing
20 cost reports including initial training by the Department
21 for providers; and

22 (8) an implementation timeline that allows an initial
23 grace period for providers to adjust internal procedures
24 and data collection.

25 Details from collected cost reports shall be made publicly
26 available on the Department's website and costs shall be used

1 to ensure the effectiveness and efficiency of Illinois
2 Medicaid rates.

3 (b) The Department and stakeholders shall develop a plan
4 by April 1, 2024. The Department shall engage stakeholders on
5 implementation of the plan.

6 ARTICLE 70.

7 Section 70-5. The Illinois Public Aid Code is amended by
8 changing Section 5-4.2 as follows:

9 (305 ILCS 5/5-4.2)

10 Sec. 5-4.2. Ambulance services payments.

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

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

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

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

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

1 Systems Act.

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

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

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

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

26 (d) This Section does not prohibit separate billing by

1 ambulance service providers for oxygen furnished while
2 providing advanced life support services.

3 (e) Beginning with services rendered on or after July 1,
4 2008, all providers of non-emergency medi-car and service car
5 transportation must certify that the driver and employee
6 attendant, as applicable, have completed a safety program
7 approved by the Department to protect both the patient and the
8 driver, prior to transporting a patient. The provider must
9 maintain this certification in its records. The provider shall
10 produce such documentation upon demand by the Department or
11 its representative. Failure to produce documentation of such
12 training shall result in recovery of any payments made by the
13 Department for services rendered by a non-certified driver or
14 employee attendant. Medi-car and service car providers must
15 maintain legible documentation in their records of the driver
16 and, as applicable, employee attendant that actually
17 transported the patient. Providers must recertify all drivers
18 and employee attendants every 3 years. If they meet the
19 established training components set forth by the Department,
20 providers of non-emergency medi-car and service car
21 transportation that are either directly or through an
22 affiliated company licensed by the Department of Public Health
23 shall be approved by the Department to have in-house safety
24 programs for training their own staff.

25 Notwithstanding the requirements above, any public
26 transportation provider of medi-car and service car

1 transportation that receives federal funding under 49 U.S.C.
2 5307 and 5311 need not certify its drivers and employee
3 attendants under this Section, since safety training is
4 already federally mandated.

5 (f) With respect to any policy or program administered by
6 the Department or its agent regarding approval of
7 non-emergency medical transportation by ground ambulance
8 service providers, including, but not limited to, the
9 Non-Emergency Transportation Services Prior Approval Program
10 (NETSPAP), the Department shall establish by rule a process by
11 which ground ambulance service providers of non-emergency
12 medical transportation may appeal any decision by the
13 Department or its agent for which no denial was received prior
14 to the time of transport that either (i) denies a request for
15 approval for payment of non-emergency transportation by means
16 of ground ambulance service or (ii) grants a request for
17 approval of non-emergency transportation by means of ground
18 ambulance service at a level of service that entitles the
19 ground ambulance service provider to a lower level of
20 compensation from the Department than the ground ambulance
21 service provider would have received as compensation for the
22 level of service requested. The rule shall be filed by
23 December 15, 2012 and shall provide that, for any decision
24 rendered by the Department or its agent on or after the date
25 the rule takes effect, the ground ambulance service provider
26 shall have 60 days from the date the decision is received to

1 file an appeal. The rule established by the Department shall
2 be, insofar as is practical, consistent with the Illinois
3 Administrative Procedure Act. The Director's decision on an
4 appeal under this Section shall be a final administrative
5 decision subject to review under the Administrative Review
6 Law.

7 (f-5) Beginning 90 days after July 20, 2012 (the effective
8 date of Public Act 97-842), (i) no denial of a request for
9 approval for payment of non-emergency transportation by means
10 of ground ambulance service, and (ii) no approval of
11 non-emergency transportation by means of ground ambulance
12 service at a level of service that entitles the ground
13 ambulance service provider to a lower level of compensation
14 from the Department than would have been received at the level
15 of service submitted by the ground ambulance service provider,
16 may be issued by the Department or its agent unless the
17 Department has submitted the criteria for determining the
18 appropriateness of the transport for first notice publication
19 in the Illinois Register pursuant to Section 5-40 of the
20 Illinois Administrative Procedure Act.

21 (f-6) Within 90 days after the effective date of this
22 amendatory Act of the 102nd General Assembly and subject to
23 federal approval, the Department shall file rules to allow for
24 the approval of ground ambulance services when the sole
25 purpose of the transport is for the navigation of stairs or the
26 assisting or lifting of a patient at a medical facility or

1 during a medical appointment in instances where the Department
2 or a contracted Medicaid managed care organization or their
3 transportation broker is unable to secure transportation
4 through any other transportation provider.

5 (f-7) For non-emergency ground ambulance claims properly
6 denied under Department policy at the time the claim is filed
7 due to failure to submit a valid Medical Certification for
8 Non-Emergency Ambulance on and after December 15, 2012 and
9 prior to January 1, 2021, the Department shall allot
10 \$2,000,000 to a pool to reimburse such claims if the provider
11 proves medical necessity for the service by other means.
12 Providers must submit any such denied claims for which they
13 seek compensation to the Department no later than December 31,
14 2021 along with documentation of medical necessity. No later
15 than May 31, 2022, the Department shall determine for which
16 claims medical necessity was established. Such claims for
17 which medical necessity was established shall be paid at the
18 rate in effect at the time of the service, provided the
19 \$2,000,000 is sufficient to pay at those rates. If the pool is
20 not sufficient, claims shall be paid at a uniform percentage
21 of the applicable rate such that the pool of \$2,000,000 is
22 exhausted. The appeal process described in subsection (f)
23 shall not be applicable to the Department's determinations
24 made in accordance with this subsection.

25 (g) Whenever a patient covered by a medical assistance
26 program under this Code or by another medical program

1 administered by the Department, including a patient covered
2 under the State's Medicaid managed care program, is being
3 transported from a facility and requires non-emergency
4 transportation including ground ambulance, medi-car, or
5 service car transportation, a Physician Certification
6 Statement as described in this Section shall be required for
7 each patient. Facilities shall develop procedures for a
8 licensed medical professional to provide a written and signed
9 Physician Certification Statement. The Physician Certification
10 Statement shall specify the level of transportation services
11 needed and complete a medical certification establishing the
12 criteria for approval of non-emergency ambulance
13 transportation, as published by the Department of Healthcare
14 and Family Services, that is met by the patient. This
15 certification shall be completed prior to ordering the
16 transportation service and prior to patient discharge. The
17 Physician Certification Statement is not required prior to
18 transport if a delay in transport can be expected to
19 negatively affect the patient outcome. If the ground ambulance
20 provider, medi-car provider, or service car provider is unable
21 to obtain the required Physician Certification Statement
22 within 10 calendar days following the date of the service, the
23 ground ambulance provider, medi-car provider, or service car
24 provider must document its attempt to obtain the requested
25 certification and may then submit the claim for payment.
26 Acceptable documentation includes a signed return receipt from

1 the U.S. Postal Service, facsimile receipt, email receipt, or
2 other similar service that evidences that the ground ambulance
3 provider, medi-car provider, or service car provider attempted
4 to obtain the required Physician Certification Statement.

5 The medical certification specifying the level and type of
6 non-emergency transportation needed shall be in the form of
7 the Physician Certification Statement on a standardized form
8 prescribed by the Department of Healthcare and Family
9 Services. Within 75 days after July 27, 2018 (the effective
10 date of Public Act 100-646), the Department of Healthcare and
11 Family Services shall develop a standardized form of the
12 Physician Certification Statement specifying the level and
13 type of transportation services needed in consultation with
14 the Department of Public Health, Medicaid managed care
15 organizations, a statewide association representing ambulance
16 providers, a statewide association representing hospitals, 3
17 statewide associations representing nursing homes, and other
18 stakeholders. The Physician Certification Statement shall
19 include, but is not limited to, the criteria necessary to
20 demonstrate medical necessity for the level of transport
21 needed as required by (i) the Department of Healthcare and
22 Family Services and (ii) the federal Centers for Medicare and
23 Medicaid Services as outlined in the Centers for Medicare and
24 Medicaid Services' Medicare Benefit Policy Manual, Pub.
25 100-02, Chap. 10, Sec. 10.2.1, et seq. The use of the Physician
26 Certification Statement shall satisfy the obligations of

1 hospitals under Section 6.22 of the Hospital Licensing Act and
2 nursing homes under Section 2-217 of the Nursing Home Care
3 Act. Implementation and acceptance of the Physician
4 Certification Statement shall take place no later than 90 days
5 after the issuance of the Physician Certification Statement by
6 the Department of Healthcare and Family Services.

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

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

23 (h) On and after July 1, 2012, the Department shall reduce
24 any rate of reimbursement for services or other payments or
25 alter any methodologies authorized by this Code to reduce any
26 rate of reimbursement for services or other payments in

1 accordance with Section 5-5e.

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

8 (j) Subject to federal approval, beginning on January 1,
9 2024, the Department shall increase the base rate of
10 reimbursement for both base charges and mileage charges for
11 medical transportation services provided by means of an air
12 ambulance to a level not lower than 50% of the Medicare
13 ambulance fee schedule rates, by designated Medicare locality,
14 in effect on January 1, 2023.

15 (Source: P.A. 101-81, eff. 7-12-19; 101-649, eff. 7-7-20;
16 102-364, eff. 1-1-22; 102-650, eff. 8-27-21; 102-813, eff.
17 5-13-22; 102-1037, eff. 6-2-22.)

18 ARTICLE 75.

19 Section 75-5. The Illinois Public Aid Code is amended by
20 changing Section 5-5.4h as follows:

21 (305 ILCS 5/5-5.4h)

22 Sec. 5-5.4h. Medicaid reimbursement for medically complex
23 for the developmentally disabled facilities licensed under the

1 MC/DD Act.

2 (a) Facilities licensed as medically complex for the
3 developmentally disabled facilities that serve severely and
4 chronically ill patients shall have a specific reimbursement
5 system designed to recognize the characteristics and needs of
6 the patients they serve.

7 (b) For dates of services starting July 1, 2013 and until a
8 new reimbursement system is designed, medically complex for
9 the developmentally disabled facilities that meet the
10 following criteria:

11 (1) serve exceptional care patients; and

12 (2) have 30% or more of their patients receiving
13 ventilator care;

14 shall receive Medicaid reimbursement on a 30-day expedited
15 schedule.

16 (c) Subject to federal approval of changes to the Title
17 XIX State Plan, for dates of services starting July 1, 2014
18 through March 31, 2019, medically complex for the
19 developmentally disabled facilities which meet the criteria in
20 subsection (b) of this Section shall receive a per diem rate
21 for clinically complex residents of \$304. Clinically complex
22 residents on a ventilator shall receive a per diem rate of
23 \$669. Subject to federal approval of changes to the Title XIX
24 State Plan, for dates of services starting April 1, 2019,
25 medically complex for the developmentally disabled facilities
26 must be reimbursed an exceptional care per diem rate, instead

1 of the base rate, for services to residents with complex or
2 extensive medical needs. Exceptional care per diem rates must
3 be paid for the conditions or services specified under
4 subsection (f) at the following per diem rates: Tier 1 \$326,
5 Tier 2 \$546, and Tier 3 \$735. Subject to federal approval, on
6 and after January 1, 2024, each tier rate shall be increased 6%
7 over the amount in effect on the effective date of this
8 amendatory Act of the 103rd General Assembly. Any
9 reimbursement increases applied to the base rate to providers
10 licensed under the ID/DD Community Care Act must also be
11 applied in an equivalent manner to each tier of exceptional
12 care per diem rates for medically complex for the
13 developmentally disabled facilities.

14 (d) For residents on a ventilator pursuant to subsection
15 (c) or subsection (f), facilities shall have a policy
16 documenting their method of routine assessment of a resident's
17 weaning potential with interventions implemented noted in the
18 resident's medical record.

19 (e) For services provided prior to April 1, 2019 and for
20 the purposes of this Section, a resident is considered
21 clinically complex if the resident requires at least one of
22 the following medical services:

23 (1) Tracheostomy care with dependence on mechanical
24 ventilation for a minimum of 6 hours each day.

25 (2) Tracheostomy care requiring suctioning at least
26 every 6 hours, room air mist or oxygen as needed, and

1 dependence on one of the treatment procedures listed under
2 paragraph (4) excluding the procedure listed in
3 subparagraph (A) of paragraph (4).

4 (3) Total parenteral nutrition or other intravenous
5 nutritional support and one of the treatment procedures
6 listed under paragraph (4).

7 (4) The following treatment procedures apply to the
8 conditions in paragraphs (2) and (3) of this subsection:

9 (A) Intermittent suctioning at least every 8 hours
10 and room air mist or oxygen as needed.

11 (B) Continuous intravenous therapy including
12 administration of therapeutic agents necessary for
13 hydration or of intravenous pharmaceuticals; or
14 intravenous pharmaceutical administration of more than
15 one agent via a peripheral or central line, without
16 continuous infusion.

17 (C) Peritoneal dialysis treatments requiring at
18 least 4 exchanges every 24 hours.

19 (D) Tube feeding via nasogastric or gastrostomy
20 tube.

21 (E) Other medical technologies required
22 continuously, which in the opinion of the attending
23 physician require the services of a professional
24 nurse.

25 (f) Complex or extensive medical needs for exceptional
26 care reimbursement. The conditions and services used for the

1 purposes of this Section have the same meanings as ascribed to
2 those conditions and services under the Minimum Data Set (MDS)
3 Resident Assessment Instrument (RAI) and specified in the most
4 recent manual. Instead of submitting minimum data set
5 assessments to the Department, medically complex for the
6 developmentally disabled facilities must document within each
7 resident's medical record the conditions or services using the
8 minimum data set documentation standards and requirements to
9 qualify for exceptional care reimbursement.

10 (1) Tier 1 reimbursement is for residents who are
11 receiving at least 51% of their caloric intake via a
12 feeding tube.

13 (2) Tier 2 reimbursement is for residents who are
14 receiving tracheostomy care without a ventilator.

15 (3) Tier 3 reimbursement is for residents who are
16 receiving tracheostomy care and ventilator care.

17 (g) For dates of services starting April 1, 2019,
18 reimbursement calculations and direct payment for services
19 provided by medically complex for the developmentally disabled
20 facilities are the responsibility of the Department of
21 Healthcare and Family Services instead of the Department of
22 Human Services. Appropriations for medically complex for the
23 developmentally disabled facilities must be shifted from the
24 Department of Human Services to the Department of Healthcare
25 and Family Services. Nothing in this Section prohibits the
26 Department of Healthcare and Family Services from paying more

1 than the rates specified in this Section. The rates in this
2 Section must be interpreted as a minimum amount. Any
3 reimbursement increases applied to providers licensed under
4 the ID/DD Community Care Act must also be applied in an
5 equivalent manner to medically complex for the developmentally
6 disabled facilities.

7 (h) The Department of Healthcare and Family Services shall
8 pay the rates in effect on March 31, 2019 until the changes
9 made to this Section by this amendatory Act of the 100th
10 General Assembly have been approved by the Centers for
11 Medicare and Medicaid Services of the U.S. Department of
12 Health and Human Services.

13 (i) The Department of Healthcare and Family Services may
14 adopt rules as allowed by the Illinois Administrative
15 Procedure Act to implement this Section; however, the
16 requirements of this Section must be implemented by the
17 Department of Healthcare and Family Services even if the
18 Department of Healthcare and Family Services has not adopted
19 rules by the implementation date of April 1, 2019.

20 (Source: P.A. 100-646, eff. 7-27-18.)

21 ARTICLE 80.

22 Section 80-5. The Illinois Public Aid Code is amended by
23 changing Section 5-4.2 as follows:

1 (305 ILCS 5/5-4.2)

2 Sec. 5-4.2. Ambulance services payments.

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

26 (b) For ambulance services provided to a recipient of aid

1 under this Article on or after January 1, 1996, the Illinois
2 Department shall reimburse ambulance service providers based
3 upon the actual distance traveled if a natural disaster,
4 weather conditions, road repairs, or traffic congestion
5 necessitates the use of a route other than the most direct
6 route.

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

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

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

25 (c-3) For purposes of this Section, "medi-car" means
26 transportation services provided to a patient who is confined

1 to a wheelchair and requires the use of a hydraulic or electric
2 lift or ramp and wheelchair lockdown when the patient's
3 condition does not require medical observation, medical
4 supervision, medical equipment, the administration of
5 medications, or the administration of oxygen.

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

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

13 (e) Beginning with services rendered on or after July 1,
14 2008, all providers of non-emergency medi-car and service car
15 transportation must certify that the driver and employee
16 attendant, as applicable, have completed a safety program
17 approved by the Department to protect both the patient and the
18 driver, prior to transporting a patient. The provider must
19 maintain this certification in its records. The provider shall
20 produce such documentation upon demand by the Department or
21 its representative. Failure to produce documentation of such
22 training shall result in recovery of any payments made by the
23 Department for services rendered by a non-certified driver or
24 employee attendant. Medi-car and service car providers must
25 maintain legible documentation in their records of the driver
26 and, as applicable, employee attendant that actually

1 transported the patient. Providers must recertify all drivers
2 and employee attendants every 3 years. If they meet the
3 established training components set forth by the Department,
4 providers of non-emergency medi-car and service car
5 transportation that are either directly or through an
6 affiliated company licensed by the Department of Public Health
7 shall be approved by the Department to have in-house safety
8 programs for training their own staff.

9 Notwithstanding the requirements above, any public
10 transportation provider of medi-car and service car
11 transportation that receives federal funding under 49 U.S.C.
12 5307 and 5311 need not certify its drivers and employee
13 attendants under this Section, since safety training is
14 already federally mandated.

15 (f) With respect to any policy or program administered by
16 the Department or its agent regarding approval of
17 non-emergency medical transportation by ground ambulance
18 service providers, including, but not limited to, the
19 Non-Emergency Transportation Services Prior Approval Program
20 (NETSPAP), the Department shall establish by rule a process by
21 which ground ambulance service providers of non-emergency
22 medical transportation may appeal any decision by the
23 Department or its agent for which no denial was received prior
24 to the time of transport that either (i) denies a request for
25 approval for payment of non-emergency transportation by means
26 of ground ambulance service or (ii) grants a request for

1 approval of non-emergency transportation by means of ground
2 ambulance service at a level of service that entitles the
3 ground ambulance service provider to a lower level of
4 compensation from the Department than the ground ambulance
5 service provider would have received as compensation for the
6 level of service requested. The rule shall be filed by
7 December 15, 2012 and shall provide that, for any decision
8 rendered by the Department or its agent on or after the date
9 the rule takes effect, the ground ambulance service provider
10 shall have 60 days from the date the decision is received to
11 file an appeal. The rule established by the Department shall
12 be, insofar as is practical, consistent with the Illinois
13 Administrative Procedure Act. The Director's decision on an
14 appeal under this Section shall be a final administrative
15 decision subject to review under the Administrative Review
16 Law.

17 (f-5) Beginning 90 days after July 20, 2012 (the effective
18 date of Public Act 97-842), (i) no denial of a request for
19 approval for payment of non-emergency transportation by means
20 of ground ambulance service, and (ii) no approval of
21 non-emergency transportation by means of ground ambulance
22 service at a level of service that entitles the ground
23 ambulance service provider to a lower level of compensation
24 from the Department than would have been received at the level
25 of service submitted by the ground ambulance service provider,
26 may be issued by the Department or its agent unless the

1 Department has submitted the criteria for determining the
2 appropriateness of the transport for first notice publication
3 in the Illinois Register pursuant to Section 5-40 of the
4 Illinois Administrative Procedure Act.

5 (f-6) Within 90 days after the effective date of this
6 amendatory Act of the 102nd General Assembly and subject to
7 federal approval, the Department shall file rules to allow for
8 the approval of ground ambulance services when the sole
9 purpose of the transport is for the navigation of stairs or the
10 assisting or lifting of a patient at a medical facility or
11 during a medical appointment in instances where the Department
12 or a contracted Medicaid managed care organization or their
13 transportation broker is unable to secure transportation
14 through any other transportation provider.

15 (f-7) For non-emergency ground ambulance claims properly
16 denied under Department policy at the time the claim is filed
17 due to failure to submit a valid Medical Certification for
18 Non-Emergency Ambulance on and after December 15, 2012 and
19 prior to January 1, 2021, the Department shall allot
20 \$2,000,000 to a pool to reimburse such claims if the provider
21 proves medical necessity for the service by other means.
22 Providers must submit any such denied claims for which they
23 seek compensation to the Department no later than December 31,
24 2021 along with documentation of medical necessity. No later
25 than May 31, 2022, the Department shall determine for which
26 claims medical necessity was established. Such claims for

1 which medical necessity was established shall be paid at the
2 rate in effect at the time of the service, provided the
3 \$2,000,000 is sufficient to pay at those rates. If the pool is
4 not sufficient, claims shall be paid at a uniform percentage
5 of the applicable rate such that the pool of \$2,000,000 is
6 exhausted. The appeal process described in subsection (f)
7 shall not be applicable to the Department's determinations
8 made in accordance with this subsection.

9 (g) Whenever a patient covered by a medical assistance
10 program under this Code or by another medical program
11 administered by the Department, including a patient covered
12 under the State's Medicaid managed care program, is being
13 transported from a facility and requires non-emergency
14 transportation including ground ambulance, medi-car, or
15 service car transportation, a Physician Certification
16 Statement as described in this Section shall be required for
17 each patient. Facilities shall develop procedures for a
18 licensed medical professional to provide a written and signed
19 Physician Certification Statement. The Physician Certification
20 Statement shall specify the level of transportation services
21 needed and complete a medical certification establishing the
22 criteria for approval of non-emergency ambulance
23 transportation, as published by the Department of Healthcare
24 and Family Services, that is met by the patient. This
25 certification shall be completed prior to ordering the
26 transportation service and prior to patient discharge. The

1 Physician Certification Statement is not required prior to
2 transport if a delay in transport can be expected to
3 negatively affect the patient outcome. If the ground ambulance
4 provider, medi-car provider, or service car provider is unable
5 to obtain the required Physician Certification Statement
6 within 10 calendar days following the date of the service, the
7 ground ambulance provider, medi-car provider, or service car
8 provider must document its attempt to obtain the requested
9 certification and may then submit the claim for payment.
10 Acceptable documentation includes a signed return receipt from
11 the U.S. Postal Service, facsimile receipt, email receipt, or
12 other similar service that evidences that the ground ambulance
13 provider, medi-car provider, or service car provider attempted
14 to obtain the required Physician Certification Statement.

15 The medical certification specifying the level and type of
16 non-emergency transportation needed shall be in the form of
17 the Physician Certification Statement on a standardized form
18 prescribed by the Department of Healthcare and Family
19 Services. Within 75 days after July 27, 2018 (the effective
20 date of Public Act 100-646), the Department of Healthcare and
21 Family Services shall develop a standardized form of the
22 Physician Certification Statement specifying the level and
23 type of transportation services needed in consultation with
24 the Department of Public Health, Medicaid managed care
25 organizations, a statewide association representing ambulance
26 providers, a statewide association representing hospitals, 3

1 statewide associations representing nursing homes, and other
2 stakeholders. The Physician Certification Statement shall
3 include, but is not limited to, the criteria necessary to
4 demonstrate medical necessity for the level of transport
5 needed as required by (i) the Department of Healthcare and
6 Family Services and (ii) the federal Centers for Medicare and
7 Medicaid Services as outlined in the Centers for Medicare and
8 Medicaid Services' Medicare Benefit Policy Manual, Pub.
9 100-02, Chap. 10, Sec. 10.2.1, et seq. The use of the Physician
10 Certification Statement shall satisfy the obligations of
11 hospitals under Section 6.22 of the Hospital Licensing Act and
12 nursing homes under Section 2-217 of the Nursing Home Care
13 Act. Implementation and acceptance of the Physician
14 Certification Statement shall take place no later than 90 days
15 after the issuance of the Physician Certification Statement by
16 the Department of Healthcare and Family Services.

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

24 Beginning October 1, 2018, the Department of Healthcare
25 and Family Services shall collect data from Medicaid managed
26 care organizations and transportation brokers, including the

1 Department's NETSPAP broker, regarding denials and appeals
2 related to the missing or incomplete Physician Certification
3 Statement forms and overall compliance with this subsection.
4 The Department of Healthcare and Family Services shall publish
5 quarterly results on its website within 15 days following the
6 end of each quarter.

7 (h) 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 (i) Subject to federal approval, on and after January 1,
13 2024 through June 30, 2026, ~~On and after July 1, 2018,~~ the
14 Department shall increase the base rate of reimbursement for
15 both base charges and mileage charges for ground ambulance
16 service providers not participating in the Ground Emergency
17 Medical Transportation (GEMT) Program for medical
18 transportation services provided by means of a ground
19 ambulance to a level not lower than 140% ~~112%~~ of the base rate
20 in effect as of January 1, 2023 ~~June 30, 2018~~.

21 (j) For the purpose of understanding ground ambulance
22 transportation services cost structures and their impact on
23 the Medical Assistance Program, the Department shall engage
24 stakeholders, including, but not limited to, a statewide
25 association representing private ground ambulance service
26 providers in Illinois, to develop recommendations for a plan

1 for the regular collection of cost data for all ground
2 ambulance transportation providers reimbursed under the
3 Illinois Title XIX State Plan. Cost data obtained through this
4 process shall be used to inform on and to ensure the
5 effectiveness and efficiency of Illinois Medicaid rates. The
6 Department shall establish a process to limit public
7 availability of portions of the cost report data determined to
8 be proprietary. This process shall be concluded and
9 recommendations shall be provided no later than April 1, 2024.

10 (Source: P.A. 101-81, eff. 7-12-19; 101-649, eff. 7-7-20;
11 102-364, eff. 1-1-22; 102-650, eff. 8-27-21; 102-813, eff.
12 5-13-22; 102-1037, eff. 6-2-22.)

13 ARTICLE 85.

14 Section 85-5. The Illinois Act on the Aging is amended by
15 changing Sections 4.02 and 4.06 as follows:

16 (20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

17 Sec. 4.02. Community Care Program. The Department shall
18 establish a program of services to prevent unnecessary
19 institutionalization of persons age 60 and older in need of
20 long term care or who are established as persons who suffer
21 from Alzheimer's disease or a related disorder under the
22 Alzheimer's Disease Assistance Act, thereby enabling them to
23 remain in their own homes or in other living arrangements.

1 Such preventive services, which may be coordinated with other
2 programs for the aged and monitored by area agencies on aging
3 in cooperation with the Department, may include, but are not
4 limited to, any or all of the following:

5 (a) (blank);

6 (b) (blank);

7 (c) home care aide services;

8 (d) personal assistant services;

9 (e) adult day services;

10 (f) home-delivered meals;

11 (g) education in self-care;

12 (h) personal care services;

13 (i) adult day health services;

14 (j) habilitation services;

15 (k) respite care;

16 (k-5) community reintegration services;

17 (k-6) flexible senior services;

18 (k-7) medication management;

19 (k-8) emergency home response;

20 (l) other nonmedical social services that may enable
21 the person to become self-supporting; or

22 (m) clearinghouse for information provided by senior
23 citizen home owners who want to rent rooms to or share
24 living space with other senior citizens.

25 The Department shall establish eligibility standards for
26 such services. In determining the amount and nature of

1 services for which a person may qualify, consideration shall
2 not be given to the value of cash, property or other assets
3 held in the name of the person's spouse pursuant to a written
4 agreement dividing marital property into equal but separate
5 shares or pursuant to a transfer of the person's interest in a
6 home to his spouse, provided that the spouse's share of the
7 marital property is not made available to the person seeking
8 such services.

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

14 The Department shall, in conjunction with the Department
15 of Public Aid (now Department of Healthcare and Family
16 Services), seek appropriate amendments under Sections 1915 and
17 1924 of the Social Security Act. The purpose of the amendments
18 shall be to extend eligibility for home and community based
19 services under Sections 1915 and 1924 of the Social Security
20 Act to persons who transfer to or for the benefit of a spouse
21 those amounts of income and resources allowed under Section
22 1924 of the Social Security Act. Subject to the approval of
23 such amendments, the Department shall extend the provisions of
24 Section 5-4 of the Illinois Public Aid Code to persons who, but
25 for the provision of home or community-based services, would
26 require the level of care provided in an institution, as is

1 provided for in federal law. Those persons no longer found to
2 be eligible for receiving noninstitutional services due to
3 changes in the eligibility criteria shall be given 45 days
4 notice prior to actual termination. Those persons receiving
5 notice of termination may contact the Department and request
6 the determination be appealed at any time during the 45 day
7 notice period. The target population identified for the
8 purposes of this Section are persons age 60 and older with an
9 identified service need. Priority shall be given to those who
10 are at imminent risk of institutionalization. The services
11 shall be provided to eligible persons age 60 and older to the
12 extent that the cost of the services together with the other
13 personal maintenance expenses of the persons are reasonably
14 related to the standards established for care in a group
15 facility appropriate to the person's condition. These
16 non-institutional services, pilot projects or experimental
17 facilities may be provided as part of or in addition to those
18 authorized by federal law or those funded and administered by
19 the Department of Human Services. The Departments of Human
20 Services, Healthcare and Family Services, Public Health,
21 Veterans' Affairs, and Commerce and Economic Opportunity and
22 other appropriate agencies of State, federal and local
23 governments shall cooperate with the Department on Aging in
24 the establishment and development of the non-institutional
25 services. The Department shall require an annual audit from
26 all personal assistant and home care aide vendors contracting

1 with the Department under this Section. The annual audit shall
2 assure that each audited vendor's procedures are in compliance
3 with Department's financial reporting guidelines requiring an
4 administrative and employee wage and benefits cost split as
5 defined in administrative rules. The audit is a public record
6 under the Freedom of Information Act. The Department shall
7 execute, relative to the nursing home prescreening project,
8 written inter-agency agreements with the Department of Human
9 Services and the Department of Healthcare and Family Services,
10 to effect the following: (1) intake procedures and common
11 eligibility criteria for those persons who are receiving
12 non-institutional services; and (2) the establishment and
13 development of non-institutional services in areas of the
14 State where they are not currently available or are
15 undeveloped. On and after July 1, 1996, all nursing home
16 prescreenings for individuals 60 years of age or older shall
17 be conducted by the Department.

18 As part of the Department on Aging's routine training of
19 case managers and case manager supervisors, the Department may
20 include information on family futures planning for persons who
21 are age 60 or older and who are caregivers of their adult
22 children with developmental disabilities. The content of the
23 training shall be at the Department's discretion.

24 The Department is authorized to establish a system of
25 recipient copayment for services provided under this Section,
26 such copayment to be based upon the recipient's ability to pay

1 but in no case to exceed the actual cost of the services
2 provided. Additionally, any portion of a person's income which
3 is equal to or less than the federal poverty standard shall not
4 be considered by the Department in determining the copayment.
5 The level of such copayment shall be adjusted whenever
6 necessary to reflect any change in the officially designated
7 federal poverty standard.

8 The Department, or the Department's authorized
9 representative, may recover the amount of moneys expended for
10 services provided to or in behalf of a person under this
11 Section by a claim against the person's estate or against the
12 estate of the person's surviving spouse, but no recovery may
13 be had until after the death of the surviving spouse, if any,
14 and then only at such time when there is no surviving child who
15 is under age 21 or blind or who has a permanent and total
16 disability. This paragraph, however, shall not bar recovery,
17 at the death of the person, of moneys for services provided to
18 the person or in behalf of the person under this Section to
19 which the person was not entitled; provided that such recovery
20 shall not be enforced against any real estate while it is
21 occupied as a homestead by the surviving spouse or other
22 dependent, if no claims by other creditors have been filed
23 against the estate, or, if such claims have been filed, they
24 remain dormant for failure of prosecution or failure of the
25 claimant to compel administration of the estate for the
26 purpose of payment. This paragraph shall not bar recovery from

1 the estate of a spouse, under Sections 1915 and 1924 of the
2 Social Security Act and Section 5-4 of the Illinois Public Aid
3 Code, who precedes a person receiving services under this
4 Section in death. All moneys for services paid to or in behalf
5 of the person under this Section shall be claimed for recovery
6 from the deceased spouse's estate. "Homestead", as used in
7 this paragraph, means the dwelling house and contiguous real
8 estate occupied by a surviving spouse or relative, as defined
9 by the rules and regulations of the Department of Healthcare
10 and Family Services, regardless of the value of the property.

11 The Department shall increase the effectiveness of the
12 existing Community Care Program by:

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

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

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

1 (4) ensuring that the determination of need tool is
2 accurate in determining the participants' level of need;
3 to achieve this, the Department, in conjunction with the
4 Older Adult Services Advisory Committee, shall institute a
5 study of the relationship between the Determination of
6 Need scores, level of need, service cost maximums, and the
7 development and utilization of service plans no later than
8 May 1, 2008; findings and recommendations shall be
9 presented to the Governor and the General Assembly no
10 later than January 1, 2009; recommendations shall include
11 all needed changes to the service cost maximums schedule
12 and additional covered services;

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

- 16 (A) bathing;
- 17 (B) grooming;
- 18 (C) toileting;
- 19 (D) nail care;
- 20 (E) transferring;
- 21 (F) respiratory services;
- 22 (G) exercise; or
- 23 (H) positioning;

24 (6) ensuring that homemaker program vendors are not
25 restricted from hiring homemakers who are family members
26 of clients or recommended by clients; the Department may

1 not, by rule or policy, require homemakers who are family
2 members of clients or recommended by clients to accept
3 assignments in homes other than the client;

4 (7) ensuring that the State may access maximum federal
5 matching funds by seeking approval for the Centers for
6 Medicare and Medicaid Services for modifications to the
7 State's home and community based services waiver and
8 additional waiver opportunities, including applying for
9 enrollment in the Balance Incentive Payment Program by May
10 1, 2013, in order to maximize federal matching funds; this
11 shall include, but not be limited to, modification that
12 reflects all changes in the Community Care Program
13 services and all increases in the services cost maximum;

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

17 (9) ensuring that services are authorized accurately
18 and consistently for the Community Care Program (CCP); the
19 Department shall implement a Service Authorization policy
20 directive; the purpose shall be to ensure that eligibility
21 and services are authorized accurately and consistently in
22 the CCP program; the policy directive shall clarify
23 service authorization guidelines to Care Coordination
24 Units and Community Care Program providers no later than
25 May 1, 2013;

26 (10) working in conjunction with Care Coordination

1 Units, the Department of Healthcare and Family Services,
2 the Department of Human Services, Community Care Program
3 providers, and other stakeholders to make improvements to
4 the Medicaid claiming processes and the Medicaid
5 enrollment procedures or requirements as needed,
6 including, but not limited to, specific policy changes or
7 rules to improve the up-front enrollment of participants
8 in the Medicaid program and specific policy changes or
9 rules to insure more prompt submission of bills to the
10 federal government to secure maximum federal matching
11 dollars as promptly as possible; the Department on Aging
12 shall have at least 3 meetings with stakeholders by
13 January 1, 2014 in order to address these improvements;

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

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

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

1 By January 1, 2009 or as soon after the end of the Cash and
2 Counseling Demonstration Project as is practicable, the
3 Department may, based on its evaluation of the demonstration
4 project, promulgate rules concerning personal assistant
5 services, to include, but need not be limited to,
6 qualifications, employment screening, rights under fair labor
7 standards, training, fiduciary agent, and supervision
8 requirements. All applicants shall be subject to the
9 provisions of the Health Care Worker Background Check Act.

10 The Department shall develop procedures to enhance
11 availability of services on evenings, weekends, and on an
12 emergency basis to meet the respite needs of caregivers.
13 Procedures shall be developed to permit the utilization of
14 services in successive blocks of 24 hours up to the monthly
15 maximum established by the Department. Workers providing these
16 services shall be appropriately trained.

17 Beginning on the effective date of this amendatory Act of
18 1991, no person may perform chore/housekeeping and home care
19 aide services under a program authorized by this Section
20 unless that person has been issued a certificate of
21 pre-service to do so by his or her employing agency.
22 Information gathered to effect such certification shall
23 include (i) the person's name, (ii) the date the person was
24 hired by his or her current employer, and (iii) the training,
25 including dates and levels. Persons engaged in the program
26 authorized by this Section before the effective date of this

1 amendatory Act of 1991 shall be issued a certificate of all
2 pre- and in-service training from his or her employer upon
3 submitting the necessary information. The employing agency
4 shall be required to retain records of all staff pre- and
5 in-service training, and shall provide such records to the
6 Department upon request and upon termination of the employer's
7 contract with the Department. In addition, the employing
8 agency is responsible for the issuance of certifications of
9 in-service training completed to their employees.

10 The Department is required to develop a system to ensure
11 that persons working as home care aides and personal
12 assistants receive increases in their wages when the federal
13 minimum wage is increased by requiring vendors to certify that
14 they are meeting the federal minimum wage statute for home
15 care aides and personal assistants. An employer that cannot
16 ensure that the minimum wage increase is being given to home
17 care aides and personal assistants shall be denied any
18 increase in reimbursement costs.

19 The Community Care Program Advisory Committee is created
20 in the Department on Aging. The Director shall appoint
21 individuals to serve in the Committee, who shall serve at
22 their own expense. Members of the Committee must abide by all
23 applicable ethics laws. The Committee shall advise the
24 Department on issues related to the Department's program of
25 services to prevent unnecessary institutionalization. The
26 Committee shall meet on a bi-monthly basis and shall serve to

1 identify and advise the Department on present and potential
2 issues affecting the service delivery network, the program's
3 clients, and the Department and to recommend solution
4 strategies. Persons appointed to the Committee shall be
5 appointed on, but not limited to, their own and their agency's
6 experience with the program, geographic representation, and
7 willingness to serve. The Director shall appoint members to
8 the Committee to represent provider, advocacy, policy
9 research, and other constituencies committed to the delivery
10 of high quality home and community-based services to older
11 adults. Representatives shall be appointed to ensure
12 representation from community care providers including, but
13 not limited to, adult day service providers, homemaker
14 providers, case coordination and case management units,
15 emergency home response providers, statewide trade or labor
16 unions that represent home care aides and direct care staff,
17 area agencies on aging, adults over age 60, membership
18 organizations representing older adults, and other
19 organizational entities, providers of care, or individuals
20 with demonstrated interest and expertise in the field of home
21 and community care as determined by the Director.

22 Nominations may be presented from any agency or State
23 association with interest in the program. The Director, or his
24 or her designee, shall serve as the permanent co-chair of the
25 advisory committee. One other co-chair shall be nominated and
26 approved by the members of the committee on an annual basis.

1 Committee members' terms of appointment shall be for 4 years
2 with one-quarter of the appointees' terms expiring each year.
3 A member shall continue to serve until his or her replacement
4 is named. The Department shall fill vacancies that have a
5 remaining term of over one year, and this replacement shall
6 occur through the annual replacement of expiring terms. The
7 Director shall designate Department staff to provide technical
8 assistance and staff support to the committee. Department
9 representation shall not constitute membership of the
10 committee. All Committee papers, issues, recommendations,
11 reports, and meeting memoranda are advisory only. The
12 Director, or his or her designee, shall make a written report,
13 as requested by the Committee, regarding issues before the
14 Committee.

15 The Department on Aging and the Department of Human
16 Services shall cooperate in the development and submission of
17 an annual report on programs and services provided under this
18 Section. Such joint report shall be filed with the Governor
19 and the General Assembly on or before March 31 ~~September 30~~
20 each year.

21 The requirement for reporting to the General Assembly
22 shall be satisfied by filing copies of the report as required
23 by Section 3.1 of the General Assembly Organization Act and
24 filing such additional copies with the State Government Report
25 Distribution Center for the General Assembly as is required
26 under paragraph (t) of Section 7 of the State Library Act.

1 Those persons previously found eligible for receiving
2 non-institutional services whose services were discontinued
3 under the Emergency Budget Act of Fiscal Year 1992, and who do
4 not meet the eligibility standards in effect on or after July
5 1, 1992, shall remain ineligible on and after July 1, 1992.
6 Those persons previously not required to cost-share and who
7 were required to cost-share effective March 1, 1992, shall
8 continue to meet cost-share requirements on and after July 1,
9 1992. Beginning July 1, 1992, all clients will be required to
10 meet eligibility, cost-share, and other requirements and will
11 have services discontinued or altered when they fail to meet
12 these requirements.

13 For the purposes of this Section, "flexible senior
14 services" refers to services that require one-time or periodic
15 expenditures including, but not limited to, respite care, home
16 modification, assistive technology, housing assistance, and
17 transportation.

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

22 The Department shall require, as a condition of
23 eligibility, enrollment in the medical assistance program
24 under Article V of the Illinois Public Aid Code (i) beginning
25 August 1, 2013, if the Auditor General has reported that the
26 Department has failed to comply with the reporting

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

6 The Department shall delay Community Care Program services
7 until an applicant is determined eligible for medical
8 assistance under Article V of the Illinois Public Aid Code (i)
9 beginning August 1, 2013, if the Auditor General has reported
10 that the Department has failed to comply with the reporting
11 requirements of Section 2-27 of the Illinois State Auditing
12 Act; or (ii) beginning June 1, 2014, if the Auditor General has
13 reported that the Department has not undertaken the required
14 actions listed in the report required by subsection (a) of
15 Section 2-27 of the Illinois State Auditing Act.

16 The Department shall implement co-payments for the
17 Community Care Program at the federally allowable maximum
18 level (i) beginning August 1, 2013, if the Auditor General has
19 reported that the Department has failed to comply with the
20 reporting requirements of Section 2-27 of the Illinois State
21 Auditing Act; or (ii) beginning June 1, 2014, if the Auditor
22 General has reported that the Department has not undertaken
23 the required actions listed in the report required by
24 subsection (a) of Section 2-27 of the Illinois State Auditing
25 Act.

26 The Department shall continue to provide other Community

1 Care Program reports as required by statute.

2 The Department shall conduct a quarterly review of Care
3 Coordination Unit performance and adherence to service
4 guidelines. The quarterly review shall be reported to the
5 Speaker of the House of Representatives, the Minority Leader
6 of the House of Representatives, the President of the Senate,
7 and the Minority Leader of the Senate. The Department shall
8 collect and report longitudinal data on the performance of
9 each care coordination unit. Nothing in this paragraph shall
10 be construed to require the Department to identify specific
11 care coordination units.

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

21 The Director of the Department on Aging shall make
22 information available to the State Board of Elections as may
23 be required by an agreement the State Board of Elections has
24 entered into with a multi-state voter registration list
25 maintenance system.

26 Within 30 days after July 6, 2017 (the effective date of

1 Public Act 100-23), rates shall be increased to \$18.29 per
2 hour, for the purpose of increasing, by at least \$.72 per hour,
3 the wages paid by those vendors to their employees who provide
4 homemaker services. The Department shall pay an enhanced rate
5 under the Community Care Program to those in-home service
6 provider agencies that offer health insurance coverage as a
7 benefit to their direct service worker employees consistent
8 with the mandates of Public Act 95-713. For State fiscal years
9 2018 and 2019, the enhanced rate shall be \$1.77 per hour. The
10 rate shall be adjusted using actuarial analysis based on the
11 cost of care, but shall not be set below \$1.77 per hour. The
12 Department shall adopt rules, including emergency rules under
13 subsections (y) and (bb) of Section 5-45 of the Illinois
14 Administrative Procedure Act, to implement the provisions of
15 this paragraph.

16 Subject to federal approval, beginning on January 1, 2024,
17 rates for adult day services shall be increased to \$16.84 per
18 hour and rates for each way transportation services for adult
19 day services shall be increased to \$12.44 per unit
20 transportation.

21 The General Assembly finds it necessary to authorize an
22 aggressive Medicaid enrollment initiative designed to maximize
23 federal Medicaid funding for the Community Care Program which
24 produces significant savings for the State of Illinois. The
25 Department on Aging shall establish and implement a Community
26 Care Program Medicaid Initiative. Under the Initiative, the

1 Department on Aging shall, at a minimum: (i) provide an
2 enhanced rate to adequately compensate care coordination units
3 to enroll eligible Community Care Program clients into
4 Medicaid; (ii) use recommendations from a stakeholder
5 committee on how best to implement the Initiative; and (iii)
6 establish requirements for State agencies to make enrollment
7 in the State's Medical Assistance program easier for seniors.

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

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

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

22 (3) One representative of the Department of Human
23 Services, appointed by the Secretary of Human Services.

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

26 (5) One individual from a non-governmental statewide

1 organization that advocates for seniors, appointed by the
2 Director of Aging.

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

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

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

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

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

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

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

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

25 (14) One individual appointed by a labor organization
26 representing frontline employees at the Department of

1 Human Services.

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

1 to the Subcommittee shall be made available to the public via
2 the Department on Aging's website.

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

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

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

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

1 conjunction with the initial intake process for new program
2 participants.

3 The Community Care Program Medicaid Initiative shall cease
4 operation 5 years after the effective date of this amendatory
5 Act of the 100th General Assembly, after which the
6 Subcommittee shall dissolve.

7 (Source: P.A. 101-10, eff. 6-5-19; 102-1071, eff. 6-10-22.)

8 (20 ILCS 105/4.06)

9 Sec. 4.06. Coordinated services for minority senior
10 citizens ~~Minority Senior Citizen Program~~. The Department shall
11 develop strategies ~~a program~~ to identify the special needs and
12 problems of minority senior citizens and evaluate the adequacy
13 and accessibility of existing services ~~programs~~ and
14 information for minority senior citizens. The Department shall
15 coordinate services for minority senior citizens through the
16 Department of Public Health, the Department of Healthcare and
17 Family Services, and the Department of Human Services.

18 The Department shall develop procedures to enhance and
19 identify availability of services and shall promulgate
20 administrative rules to establish the responsibilities of the
21 Department.

22 The Department on Aging, the Department of Public Health,
23 the Department of Healthcare and Family Services, and the
24 Department of Human Services shall cooperate in the
25 development and submission of an annual report on ~~programs and~~

1 services provided under this Section. The joint report shall
2 be filed with the Governor and the General Assembly on or
3 before September 30 of each year.

4 (Source: P.A. 95-331, eff. 8-21-07.)

5 ARTICLE 90.

6 Section 90-5. The Illinois Act on the Aging is amended by
7 changing Sections 4.02 and 4.07 as follows:

8 (20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

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

20 (a) (blank);

21 (b) (blank);

22 (c) home care aide services;

23 (d) personal assistant services;

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

17 The Department shall establish eligibility standards for

18 such services. In determining the amount and nature of

19 services for which a person may qualify, consideration shall

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

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

22 agreement dividing marital property into equal but separate

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

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

25 marital property is not made available to the person seeking

26 such services.

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

6 The Department shall, in conjunction with the Department
7 of Public Aid (now Department of Healthcare and Family
8 Services), seek appropriate amendments under Sections 1915 and
9 1924 of the Social Security Act. The purpose of the amendments
10 shall be to extend eligibility for home and community based
11 services under Sections 1915 and 1924 of the Social Security
12 Act to persons who transfer to or for the benefit of a spouse
13 those amounts of income and resources allowed under Section
14 1924 of the Social Security Act. Subject to the approval of
15 such amendments, the Department shall extend the provisions of
16 Section 5-4 of the Illinois Public Aid Code to persons who, but
17 for the provision of home or community-based services, would
18 require the level of care provided in an institution, as is
19 provided for in federal law. Those persons no longer found to
20 be eligible for receiving noninstitutional services due to
21 changes in the eligibility criteria shall be given 45 days
22 notice prior to actual termination. Those persons receiving
23 notice of termination may contact the Department and request
24 the determination be appealed at any time during the 45 day
25 notice period. The target population identified for the
26 purposes of this Section are persons age 60 and older with an

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

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

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

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

26 The Department, or the Department's authorized

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

1 by the rules and regulations of the Department of Healthcare
2 and Family Services, regardless of the value of the property.

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

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

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

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

19 (4) ensuring that the determination of need tool is
20 accurate in determining the participants' level of need;
21 to achieve this, the Department, in conjunction with the
22 Older Adult Services Advisory Committee, shall institute a
23 study of the relationship between the Determination of
24 Need scores, level of need, service cost maximums, and the
25 development and utilization of service plans no later than
26 May 1, 2008; findings and recommendations shall be

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

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

8 (A) bathing;

9 (B) grooming;

10 (C) toileting;

11 (D) nail care;

12 (E) transferring;

13 (F) respiratory services;

14 (G) exercise; or

15 (H) positioning;

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

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

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

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

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

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

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

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

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

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

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

1 provisions of the Health Care Worker Background Check Act.

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

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

1 in-service training completed to their employees.

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

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

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

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

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

7 The Department on Aging and the Department of Human
8 Services shall cooperate in the development and submission of
9 an annual report on programs and services provided under this
10 Section. Such joint report shall be filed with the Governor
11 and the General Assembly on or before March 31 of the following
12 fiscal year ~~September 30 each year.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 The General Assembly finds it necessary to authorize an
9 aggressive Medicaid enrollment initiative designed to maximize
10 federal Medicaid funding for the Community Care Program which
11 produces significant savings for the State of Illinois. The
12 Department on Aging shall establish and implement a Community
13 Care Program Medicaid Initiative. Under the Initiative, the
14 Department on Aging shall, at a minimum: (i) provide an
15 enhanced rate to adequately compensate care coordination units
16 to enroll eligible Community Care Program clients into
17 Medicaid; (ii) use recommendations from a stakeholder
18 committee on how best to implement the Initiative; and (iii)
19 establish requirements for State agencies to make enrollment
20 in the State's Medical Assistance program easier for seniors.

21 The Community Care Program Medicaid Enrollment Oversight
22 Subcommittee is created as a subcommittee of the Older Adult
23 Services Advisory Committee established in Section 35 of the
24 Older Adult Services Act to make recommendations on how best
25 to increase the number of medical assistance recipients who
26 are enrolled in the Community Care Program. The Subcommittee

1 shall consist of all of the following persons who must be
2 appointed within 30 days after the effective date of this
3 amendatory Act of the 100th General Assembly:

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

6 (2) One representative of the Department of Healthcare
7 and Family Services, appointed by the Director of
8 Healthcare and Family Services.

9 (3) One representative of the Department of Human
10 Services, appointed by the Secretary of Human Services.

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

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

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

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

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

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

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

3 (11) One member of the Senate, who shall serve as
4 co-chairperson, appointed by the Minority Leader of the
5 Senate.

6 (12) One member of the House of Representatives, who
7 shall serve as co-chairperson, appointed by the Speaker of
8 the House of Representatives.

9 (13) One member of the House of Representatives, who
10 shall serve as co-chairperson, appointed by the Minority
11 Leader of the House of Representatives.

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

15 The Subcommittee shall provide oversight to the Community
16 Care Program Medicaid Initiative and shall meet quarterly. At
17 each Subcommittee meeting the Department on Aging shall
18 provide the following data sets to the Subcommittee: (A) the
19 number of Illinois residents, categorized by planning and
20 service area, who are receiving services under the Community
21 Care Program and are enrolled in the State's Medical
22 Assistance Program; (B) the number of Illinois residents,
23 categorized by planning and service area, who are receiving
24 services under the Community Care Program, but are not
25 enrolled in the State's Medical Assistance Program; and (C)
26 the number of Illinois residents, categorized by planning and

1 service area, who are receiving services under the Community
2 Care Program and are eligible for benefits under the State's
3 Medical Assistance Program, but are not enrolled in the
4 State's Medical Assistance Program. In addition to this data,
5 the Department on Aging shall provide the Subcommittee with
6 plans on how the Department on Aging will reduce the number of
7 Illinois residents who are not enrolled in the State's Medical
8 Assistance Program but who are eligible for medical assistance
9 benefits. The Department on Aging shall enroll in the State's
10 Medical Assistance Program those Illinois residents who
11 receive services under the Community Care Program and are
12 eligible for medical assistance benefits but are not enrolled
13 in the State's Medicaid Assistance Program. The data provided
14 to the Subcommittee shall be made available to the public via
15 the Department on Aging's website.

16 The Department on Aging, with the involvement of the
17 Subcommittee, shall collaborate with the Department of Human
18 Services and the Department of Healthcare and Family Services
19 on how best to achieve the responsibilities of the Community
20 Care Program Medicaid Initiative.

21 The Department on Aging, the Department of Human Services,
22 and the Department of Healthcare and Family Services shall
23 coordinate and implement a streamlined process for seniors to
24 access benefits under the State's Medical Assistance Program.

25 The Subcommittee shall collaborate with the Department of
26 Human Services on the adoption of a uniform application

1 submission process. The Department of Human Services and any
2 other State agency involved with processing the medical
3 assistance application of any person enrolled in the Community
4 Care Program shall include the appropriate care coordination
5 unit in all communications related to the determination or
6 status of the application.

7 The Community Care Program Medicaid Initiative shall
8 provide targeted funding to care coordination units to help
9 seniors complete their applications for medical assistance
10 benefits. On and after July 1, 2019, care coordination units
11 shall receive no less than \$200 per completed application,
12 which rate may be included in a bundled rate for initial intake
13 services when Medicaid application assistance is provided in
14 conjunction with the initial intake process for new program
15 participants.

16 The Community Care Program Medicaid Initiative shall cease
17 operation 5 years after the effective date of this amendatory
18 Act of the 100th General Assembly, after which the
19 Subcommittee shall dissolve.

20 (Source: P.A. 101-10, eff. 6-5-19; 102-1071, eff. 6-10-22.)

21 (20 ILCS 105/4.07)

22 Sec. 4.07. Home-delivered meals.

23 (a) Every citizen of the State of Illinois who qualifies
24 for home-delivered meals under the federal Older Americans Act
25 shall be provided services, subject to appropriation. The

1 Department shall file a report with the General Assembly and
2 the Illinois Council on Aging by March 31 of the following
3 fiscal year ~~January 1 of each year~~. The report shall include,
4 but not be limited to, the following information: (i)
5 estimates, by county, of citizens denied service due to
6 insufficient funds during the preceding fiscal year and the
7 potential impact on service delivery of any additional funds
8 appropriated for the current fiscal year; (ii) geographic
9 areas and special populations unserved and underserved in the
10 preceding fiscal year; (iii) estimates of additional funds
11 needed to permit the full funding of the program and the
12 statewide provision of services in the next fiscal year,
13 including staffing and equipment needed to prepare and deliver
14 meals; (iv) recommendations for increasing the amount of
15 federal funding captured for the program; (v) recommendations
16 for serving unserved and underserved areas and special
17 populations, to include rural areas, dietetic meals, weekend
18 meals, and 2 or more meals per day; and (vi) any other
19 information needed to assist the General Assembly and the
20 Illinois Council on Aging in developing a plan to address
21 unserved and underserved areas of the State.

22 (b) Subject to appropriation, on an annual basis each
23 recipient of home-delivered meals shall receive a fact sheet
24 developed by the Department on Aging with a current list of
25 toll-free numbers to access information on various health
26 conditions, elder abuse, and programs for persons 60 years of

1 age and older. The fact sheet shall be written in a language
2 that the client understands, if possible. In addition, each
3 recipient of home-delivered meals shall receive updates on any
4 new program for which persons 60 years of age and older may be
5 eligible.

6 (Source: P.A. 102-253, eff. 8-6-21.)

7 Section 90-10. The Respite Program Act is amended by
8 changing Section 12 as follows:

9 (320 ILCS 10/12) (from Ch. 23, par. 6212)

10 Sec. 12. Annual report. The Director shall submit a report
11 by March 31 of the following fiscal year ~~each year~~ to the
12 Governor and the General Assembly detailing the progress of
13 the respite care services provided under this Act and shall
14 also include an estimate of the demand for respite care
15 services over the next 10 years.

16 (Source: P.A. 100-972, eff. 1-1-19.)

17 ARTICLE 95.

18 Section 95-5. The Hospital Licensing Act is amended by
19 changing Section 6.09 as follows:

20 (210 ILCS 85/6.09) (from Ch. 111 1/2, par. 147.09)

21 Sec. 6.09. (a) In order to facilitate the orderly

1 transition of aged patients and patients with disabilities
2 from hospitals to post-hospital care, whenever a patient who
3 qualifies for the federal Medicare program is hospitalized,
4 the patient shall be notified of discharge at least 24 hours
5 prior to discharge from the hospital. With regard to pending
6 discharges to a skilled nursing facility, the hospital must
7 notify the case coordination unit, as defined in 89 Ill. Adm.
8 Code 240.260, at least 24 hours prior to discharge. When the
9 assessment is completed in the hospital, the case coordination
10 unit shall provide a copy of the required assessment
11 documentation directly to the nursing home to which the
12 patient is being discharged prior to discharge. The Department
13 on Aging shall provide notice of this requirement to case
14 coordination units. When a case coordination unit is unable to
15 complete an assessment in a hospital prior to the discharge of
16 a patient, 60 years of age or older, to a nursing home, the
17 case coordination unit shall notify the Department on Aging
18 which shall notify the Department of Healthcare and Family
19 Services. ~~The Department of Healthcare and Family Services and~~
20 ~~the~~ Department on Aging shall adopt rules to address these
21 instances to ensure that the patient is able to access nursing
22 home care, the nursing home is not penalized for accepting the
23 admission, and the patient's timely discharge from the
24 hospital is not delayed, to the extent permitted under federal
25 law or regulation. Nothing in this subsection shall preclude
26 federal requirements for a pre-admission screening/mental

1 health (PAS/MH) as required under Section 2-201.5 of the
2 Nursing Home Care Act or State or federal law or regulation. If
3 home health services are ordered, the hospital must inform its
4 designated case coordination unit, as defined in 89 Ill. Adm.
5 Code 240.260, of the pending discharge and must provide the
6 patient with the case coordination unit's telephone number and
7 other contact information.

8 (b) Every hospital shall develop procedures for a
9 physician with medical staff privileges at the hospital or any
10 appropriate medical staff member to provide the discharge
11 notice prescribed in subsection (a) of this Section. The
12 procedures must include prohibitions against discharging or
13 referring a patient to any of the following if unlicensed,
14 uncertified, or unregistered: (i) a board and care facility,
15 as defined in the Board and Care Home Act; (ii) an assisted
16 living and shared housing establishment, as defined in the
17 Assisted Living and Shared Housing Act; (iii) a facility
18 licensed under the Nursing Home Care Act, the Specialized
19 Mental Health Rehabilitation Act of 2013, the ID/DD Community
20 Care Act, or the MC/DD Act; (iv) a supportive living facility,
21 as defined in Section 5-5.01a of the Illinois Public Aid Code;
22 or (v) a free-standing hospice facility licensed under the
23 Hospice Program Licensing Act if licensure, certification, or
24 registration is required. The Department of Public Health
25 shall annually provide hospitals with a list of licensed,
26 certified, or registered board and care facilities, assisted

1 living and shared housing establishments, nursing homes,
2 supportive living facilities, facilities licensed under the
3 ID/DD Community Care Act, the MC/DD Act, or the Specialized
4 Mental Health Rehabilitation Act of 2013, and hospice
5 facilities. Reliance upon this list by a hospital shall
6 satisfy compliance with this requirement. The procedure may
7 also include a waiver for any case in which a discharge notice
8 is not feasible due to a short length of stay in the hospital
9 by the patient, or for any case in which the patient
10 voluntarily desires to leave the hospital before the
11 expiration of the 24 hour period.

12 (c) At least 24 hours prior to discharge from the
13 hospital, the patient shall receive written information on the
14 patient's right to appeal the discharge pursuant to the
15 federal Medicare program, including the steps to follow to
16 appeal the discharge and the appropriate telephone number to
17 call in case the patient intends to appeal the discharge.

18 (d) Before transfer of a patient to a long term care
19 facility licensed under the Nursing Home Care Act where
20 elderly persons reside, a hospital shall as soon as
21 practicable initiate a name-based criminal history background
22 check by electronic submission to the Illinois State Police
23 for all persons between the ages of 18 and 70 years; provided,
24 however, that a hospital shall be required to initiate such a
25 background check only with respect to patients who:

26 (1) are transferring to a long term care facility for

1 the first time;

2 (2) have been in the hospital more than 5 days;

3 (3) are reasonably expected to remain at the long term
4 care facility for more than 30 days;

5 (4) have a known history of serious mental illness or
6 substance abuse; and

7 (5) are independently ambulatory or mobile for more
8 than a temporary period of time.

9 A hospital may also request a criminal history background
10 check for a patient who does not meet any of the criteria set
11 forth in items (1) through (5).

12 A hospital shall notify a long term care facility if the
13 hospital has initiated a criminal history background check on
14 a patient being discharged to that facility. In all
15 circumstances in which the hospital is required by this
16 subsection to initiate the criminal history background check,
17 the transfer to the long term care facility may proceed
18 regardless of the availability of criminal history results.
19 Upon receipt of the results, the hospital shall promptly
20 forward the results to the appropriate long term care
21 facility. If the results of the background check are
22 inconclusive, the hospital shall have no additional duty or
23 obligation to seek additional information from, or about, the
24 patient.

25 (Source: P.A. 102-538, eff. 8-20-21.)

1 Section 95-10. The Illinois Insurance Code is amended by
2 changing Section 5.5 as follows:

3 (215 ILCS 5/5.5)

4 Sec. 5.5. Compliance with the Department of Healthcare and
5 Family Services. A company authorized to do business in this
6 State or accredited by the State to issue policies of health
7 insurance, including but not limited to, self-insured plans,
8 group health plans (as defined in Section 607(1) of the
9 Employee Retirement Income Security Act of 1974), service
10 benefit plans, managed care organizations, pharmacy benefit
11 managers, or other parties that are by statute, contract, or
12 agreement legally responsible for payment of a claim for a
13 health care item or service as a condition of doing business in
14 the State must:

15 (1) provide to the Department of Healthcare and Family
16 Services, or any successor agency, on at least a quarterly
17 basis if so requested by the Department, information to
18 determine during what period any individual may be, or may
19 have been, covered by a health insurer and the nature of
20 the coverage that is or was provided by the health
21 insurer, including the name, address, and identifying
22 number of the plan;

23 (2) accept the State's right of recovery and the
24 assignment to the State of any right of an individual or
25 other entity to payment from the party for an item or

1 service for which payment has been made under the medical
2 programs of the Department of Healthcare and Family
3 Services, or any successor or authorized agency, under
4 this Code, ~~or~~ the Illinois Public Aid Code, or any other
5 applicable law; and (other than parties expressly excluded
6 under 42 U.S.C. 1396a(a)(25)(I)(ii)(II)) accept
7 authorization provided by the State that the item or
8 service is covered under such medical programs for the
9 individual, as if the State's authorization was the prior
10 authorization made by the company for the item or service;

11 (3) not later than 60 days after receiving ~~respond to~~
12 any inquiry by the Department of Healthcare and Family
13 Services regarding a claim for payment for any health care
14 item or service that is submitted not later than 3 years
15 after the date of the provision of such health care item or
16 service, respond to such inquiry; and

17 (4) agree not to deny a claim submitted by the
18 Department of Healthcare and Family Services solely on the
19 basis of the date of submission of the claim, the type or
20 format of the claim form, ~~or~~ a failure to present proper
21 documentation at the point-of-sale that is the basis of
22 the claim, or (other than parties expressly excluded under
23 42 U.S.C. 1396a(a)(25)(I)(iv)) a failure to obtain a prior
24 authorization for the item or service for which the claim
25 is being submitted if (i) the claim is submitted by the
26 Department of Healthcare and Family Services within the

1 3-year period beginning on the date on which the item or
2 service was furnished and (ii) any action by the
3 Department of Healthcare and Family Services to enforce
4 its rights with respect to such claim is commenced within
5 6 years of its submission of such claim.

6 The Department of Healthcare and Family Services may
7 impose an administrative penalty as provided under Section
8 12-4.45 of the Illinois Public Aid Code on entities that have
9 established a pattern of failure to provide the information
10 required under this Section, or in cases in which the
11 Department of Healthcare and Family Services has determined
12 that an entity that provides health insurance coverage has
13 established a pattern of failure to provide the information
14 required under this Section, and has subsequently certified
15 that determination, along with supporting documentation, to
16 the Director of the Department of Insurance, the Director of
17 the Department of Insurance, based upon the certification of
18 determination made by the Department of Healthcare and Family
19 Services, may commence regulatory proceedings in accordance
20 with all applicable provisions of the Illinois Insurance Code.
21 (Source: P.A. 98-130, eff. 8-2-13.)

22 Section 95-15. The Illinois Public Aid Code is amended by
23 changing Sections 5-5 and 12-8 as follows:

24 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 On and after January 1, 2022, the Department of Healthcare

1 and Family Services shall administer and regulate a
2 school-based dental program that allows for the out-of-office
3 delivery of preventative dental services in a school setting
4 to children under 19 years of age. The Department shall
5 establish, by rule, guidelines for participation by providers
6 and set requirements for follow-up referral care based on the
7 requirements established in the Dental Office Reference Manual
8 published by the Department that establishes the requirements
9 for dentists participating in the All Kids Dental School
10 Program. Every effort shall be made by the Department when
11 developing the program requirements to consider the different
12 geographic differences of both urban and rural areas of the
13 State for initial treatment and necessary follow-up care. No
14 provider shall be charged a fee by any unit of local government
15 to participate in the school-based dental program administered
16 by the Department. Nothing in this paragraph shall be
17 construed to limit or preempt a home rule unit's or school
18 district's authority to establish, change, or administer a
19 school-based dental program in addition to, or independent of,
20 the school-based dental program administered by the
21 Department.

22 The Illinois Department, by rule, may distinguish and
23 classify the medical services to be provided only in
24 accordance with the classes of persons designated in Section
25 5-2.

26 The Department of Healthcare and Family Services must

1 provide coverage and reimbursement for amino acid-based
2 elemental formulas, regardless of delivery method, for the
3 diagnosis and treatment of (i) eosinophilic disorders and (ii)
4 short bowel syndrome when the prescribing physician has issued
5 a written order stating that the amino acid-based elemental
6 formula is medically necessary.

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

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

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

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

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

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

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

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

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

20 For purposes of this Section:

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

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

1 breast.

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

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

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

1 for the cost of coverage for breast tomosynthesis set forth in
2 this paragraph.

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

8 On and after January 1, 2012, providers participating in a
9 quality improvement program approved by the Department shall
10 be reimbursed for screening and diagnostic mammography at the
11 same rate as the Medicare program's rates, including the
12 increased reimbursement for digital mammography and, after
13 January 1, 2023 (the effective date of Public Act 102-1018)
14 ~~this amendatory Act of the 102nd General Assembly~~, breast
15 tomosynthesis.

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

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

26 The Department shall convene an expert panel, including

1 representatives of hospitals, free-standing breast cancer
2 treatment centers, breast cancer quality organizations, and
3 doctors, including breast surgeons, reconstructive breast
4 surgeons, oncologists, and primary care providers to establish
5 quality standards for breast cancer treatment.

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

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

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

1 who meet that goal.

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

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

24 The Department shall provide coverage and reimbursement
25 for a human papillomavirus (HPV) vaccine that is approved for
26 marketing by the federal Food and Drug Administration for all

1 persons between the ages of 9 and 45. Subject to federal
2 approval, the Department shall provide coverage and
3 reimbursement for a human papillomavirus (HPV) vaccine for ~~and~~
4 persons of the age of 46 and above who have been diagnosed with
5 cervical dysplasia with a high risk of recurrence or
6 progression. The Department shall disallow any
7 preauthorization requirements for the administration of the
8 human papillomavirus (HPV) vaccine.

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

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

1 of Human Services.

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

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

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

21 The Illinois Department shall establish such regulations
22 governing the dispensing of health services under this Article
23 as it shall deem appropriate. The Department should seek the
24 advice of formal professional advisory committees appointed by
25 the Director of the Illinois Department for the purpose of
26 providing regular advice on policy and administrative matters,

1 information dissemination and educational activities for
2 medical and health care providers, and consistency in
3 procedures to the Illinois Department.

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

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

24 (1) Physicians participating in a Partnership and
25 providing certain services, which shall be determined by
26 the Illinois Department, to persons in areas covered by

1 the Partnership may receive an additional surcharge for
2 such services.

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

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

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

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

1 service providers.

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

5 The Illinois Department shall require health care
6 providers to maintain records that document the medical care
7 and services provided to recipients of Medical Assistance
8 under this Article. Such records must be retained for a period
9 of not less than 6 years from the date of service or as
10 provided by applicable State law, whichever period is longer,
11 except that if an audit is initiated within the required
12 retention period then the records must be retained until the
13 audit is completed and every exception is resolved. The
14 Illinois Department shall require health care providers to
15 make available, when authorized by the patient, in writing,
16 the medical records in a timely fashion to other health care
17 providers who are treating or serving persons eligible for
18 Medical Assistance under this Article. All dispensers of
19 medical services shall be required to maintain and retain
20 business and professional records sufficient to fully and
21 accurately document the nature, scope, details and receipt of
22 the health care provided to persons eligible for medical
23 assistance under this Code, in accordance with regulations
24 promulgated by the Illinois Department. The rules and
25 regulations shall require that proof of the receipt of
26 prescription drugs, dentures, prosthetic devices and

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

20 Notwithstanding any other law to the contrary, the
21 Illinois Department shall, within 365 days after July 22, 2013
22 (the effective date of Public Act 98-104), establish
23 procedures to permit skilled care facilities licensed under
24 the Nursing Home Care Act to submit monthly billing claims for
25 reimbursement purposes. Following development of these
26 procedures, the Department shall, by July 1, 2016, test the

1 viability of the new system and implement any necessary
2 operational or structural changes to its information
3 technology platforms in order to allow for the direct
4 acceptance and payment of nursing home claims.

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

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

25 The Illinois Department may require that all dispensers of
26 medical services desiring to participate in the medical

1 assistance program established under this Article disclose,
2 under such terms and conditions as the Illinois Department may
3 by rule establish, all inquiries from clients and attorneys
4 regarding medical bills paid by the Illinois Department, which
5 inquiries could indicate potential existence of claims or
6 liens for the Illinois Department.

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

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

19 Prior to enrollment and during the conditional enrollment
20 period in the medical assistance program, all vendors shall be
21 subject to enhanced oversight, screening, and review based on
22 the risk of fraud, waste, and abuse that is posed by the
23 category of risk of the vendor. The Illinois Department shall
24 establish the procedures for oversight, screening, and review,
25 which may include, but need not be limited to: criminal and
26 financial background checks; fingerprinting; license,

1 certification, and authorization verifications; unscheduled or
2 unannounced site visits; database checks; prepayment audit
3 reviews; audits; payment caps; payment suspensions; and other
4 screening as required by federal or State law.

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

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

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

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

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

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

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

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

1 documents, including all prescreening information, must be
2 submitted through MEDI or REV. Confirmation numbers assigned
3 to an accepted transaction shall be retained by a facility to
4 verify timely submittal. Once an admission transaction has
5 been completed, all resubmitted claims following prior
6 rejection are subject to receipt no later than 180 days after
7 the admission transaction has been completed.

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

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

26 The Illinois Department shall enter into agreements with

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

17 Beginning in fiscal year 2013, the Illinois Department
18 shall set forth a request for information to identify the
19 benefits of a pre-payment, post-adjudication, and post-edit
20 claims system with the goals of streamlining claims processing
21 and provider reimbursement, reducing the number of pending or
22 rejected claims, and helping to ensure a more transparent
23 adjudication process through the utilization of: (i) provider
24 data verification and provider screening technology; and (ii)
25 clinical code editing; and (iii) pre-pay, pre-adjudicated ~~pre-~~
26 or post-adjudicated predictive modeling with an integrated

1 case management system with link analysis. Such a request for
2 information shall not be considered as a request for proposal
3 or as an obligation on the part of the Illinois Department to
4 take any action or acquire any products or services.

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

26 The Department shall require, by rule, all providers of

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

8 In order to promote environmental responsibility, meet the
9 needs of recipients and enrollees, and achieve significant
10 cost savings, the Department, or a managed care organization
11 under contract with the Department, may provide recipients or
12 managed care enrollees who have a prescription or Certificate
13 of Medical Necessity access to refurbished durable medical
14 equipment under this Section (excluding prosthetic and
15 orthotic devices as defined in the Orthotics, Prosthetics, and
16 Pedorthics Practice Act and complex rehabilitation technology
17 products and associated services) through the State's
18 assistive technology program's reutilization program, using
19 staff with the Assistive Technology Professional (ATP)
20 Certification if the refurbished durable medical equipment:
21 (i) is available; (ii) is less expensive, including shipping
22 costs, than new durable medical equipment of the same type;
23 (iii) is able to withstand at least 3 years of use; (iv) is
24 cleaned, disinfected, sterilized, and safe in accordance with
25 federal Food and Drug Administration regulations and guidance
26 governing the reprocessing of medical devices in health care

1 settings; and (v) equally meets the needs of the recipient or
2 enrollee. The reutilization program shall confirm that the
3 recipient or enrollee is not already in receipt of the same or
4 similar equipment from another service provider, and that the
5 refurbished durable medical equipment equally meets the needs
6 of the recipient or enrollee. Nothing in this paragraph shall
7 be construed to limit recipient or enrollee choice to obtain
8 new durable medical equipment or place any additional prior
9 authorization conditions on enrollees of managed care
10 organizations.

11 The Department shall execute, relative to the nursing home
12 prescreening project, written inter-agency agreements with the
13 Department of Human Services and the Department on Aging, to
14 effect the following: (i) intake procedures and common
15 eligibility criteria for those persons who are receiving
16 non-institutional services; and (ii) the establishment and
17 development of non-institutional services in areas of the
18 State where they are not currently available or are
19 undeveloped; and (iii) notwithstanding any other provision of
20 law, subject to federal approval, on and after July 1, 2012, an
21 increase in the determination of need (DON) scores from 29 to
22 37 for applicants for institutional and home and
23 community-based long term care; if and only if federal
24 approval is not granted, the Department may, in conjunction
25 with other affected agencies, implement utilization controls
26 or changes in benefit packages to effectuate a similar savings

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

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

23 The Illinois Department shall report annually to the
24 General Assembly, no later than the second Friday in April of
25 1979 and each year thereafter, in regard to:

26 (a) actual statistics and trends in utilization of

1 medical services by public aid recipients;

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

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

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

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

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

24 On and after July 1, 2012, the Department shall reduce any
25 rate of reimbursement for services or other payments or alter
26 any methodologies authorized by this Code to reduce any rate

1 of reimbursement for services or other payments in accordance
2 with Section 5-5e.

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

19 Notwithstanding any other provision of this Code to the
20 contrary, on or after July 1, 2015, all FDA approved forms of
21 medication assisted treatment prescribed for the treatment of
22 alcohol dependence or treatment of opioid dependence shall be
23 covered under both fee for service and managed care medical
24 assistance programs for persons who are otherwise eligible for
25 medical assistance under this Article and shall not be subject
26 to any (1) utilization control, other than those established

1 under the American Society of Addiction Medicine patient
2 placement criteria, (2) prior authorization mandate, or (3)
3 lifetime restriction limit mandate.

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

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

1 transmitted infections, medical monitoring, assorted labs, and
2 counseling to reduce the likelihood of HIV infection among
3 individuals who are not infected with HIV but who are at high
4 risk of HIV infection.

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

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

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

1 the Code of Federal Regulations, PACE program services shall
2 become a covered benefit of the medical assistance program,
3 subject to criteria established in accordance with all
4 applicable laws.

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

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

21 (Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20;
22 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article
23 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section
24 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22;
25 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff.
26 1-1-22; 102-665, eff. 10-8-21; 102-813, eff. 5-13-22;

1 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22; 102-1038 eff.
2 1-1-23; revised 2-5-23.)

3 (305 ILCS 5/12-8) (from Ch. 23, par. 12-8)

4 Sec. 12-8. Public Assistance Emergency Revolving Fund -
5 Uses. The Public Assistance Emergency Revolving Fund,
6 established by Act approved July 8, 1955 shall be held by the
7 Illinois Department and shall be used for the following
8 purposes:

9 1. To provide immediate financial aid to applicants in
10 acute need who have been determined eligible for aid under
11 Articles III, IV, or V.

12 2. To provide emergency aid to recipients under said
13 Articles who have failed to receive their grants because
14 of mail box or other thefts, or who are victims of a
15 burnout, eviction, or other circumstances causing
16 privation, in which cases the delays incident to the
17 issuance of grants from appropriations would cause
18 hardship and suffering.

19 3. To provide emergency aid for transportation, meals
20 and lodging to applicants who are referred to cities other
21 than where they reside for physical examinations to
22 establish blindness or disability, or to determine the
23 incapacity of the parent of a dependent child.

24 4. To provide emergency transportation expense
25 allowances to recipients engaged in vocational training

1 and rehabilitation projects.

2 5. To assist public aid applicants in obtaining copies
3 of birth certificates, death certificates, marriage
4 licenses or other similar legal documents which may
5 facilitate the verification of eligibility for public aid
6 under this Code.

7 6. To provide immediate payments to current or former
8 recipients of child support enforcement services, or
9 refunds to responsible relatives, for child support made
10 to the Illinois Department under Title IV-D of the Social
11 Security Act when such recipients of services or
12 responsible relatives are legally entitled to all or part
13 of such child support payments under applicable State or
14 federal law.

15 7. To provide payments to individuals or providers of
16 transportation to and from medical care for the benefit of
17 recipients under Articles III, IV, V, and VI.

18 8. To provide immediate payment of fees, as follows:

19 (A) To sheriffs and other public officials
20 authorized by law to serve process in judicial and
21 administrative child support actions in the State of
22 Illinois and other states.

23 (B) To county clerks, recorders of deeds, and
24 other public officials and keepers of real property
25 records in order to perfect and release real property
26 liens.

1 (C) To State and local officials in connection
2 with the processing of Qualified Illinois Domestic
3 Relations Orders.

4 (D) To the State Registrar of Vital Records, local
5 registrars of vital records, or other public officials
6 and keepers of voluntary acknowledgment of paternity
7 forms.

8 Disbursements from the Public Assistance Emergency
9 Revolving Fund shall be made by the Illinois Department.

10 Expenditures from the Public Assistance Emergency
11 Revolving Fund shall be for purposes which are properly
12 chargeable to appropriations made to the Illinois Department,
13 or, in the case of payments under subparagraphs 6 and 8, to the
14 Child Support Enforcement Trust Fund or the Child Support
15 Administrative Fund, except that no expenditure, other than
16 payment of the fees provided for under subparagraph 8 of this
17 Section, shall be made for purposes which are properly
18 chargeable to appropriations for the following objects:
19 personal services; extra help; state contributions to
20 retirement system; state contributions to Social Security;
21 state contributions for employee group insurance; contractual
22 services; travel; commodities; printing; equipment; electronic
23 data processing; operation of auto equipment;
24 telecommunications services; library books; and refunds. The
25 Illinois Department shall reimburse the Public Assistance
26 Emergency Revolving Fund by warrants drawn by the State

1 Comptroller on the appropriation or appropriations which are
2 so chargeable, or, in the case of payments under subparagraphs
3 6 and 8, by warrants drawn on the Child Support Enforcement
4 Trust Fund or the Child Support Administrative Fund, payable
5 to the Revolving Fund.

6 (Source: P.A. 97-735, eff. 7-3-12.)

7 ARTICLE 100.

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

10 (305 ILCS 5/5-5.01a)

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

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

16 A supportive living facility is (i) a free-standing
17 facility or (ii) a distinct physical and operational entity
18 within a mixed-use building that meets the criteria
19 established in subsection (d). A supportive living facility
20 integrates housing with health, personal care, and supportive
21 services and is a designated setting that offers residents
22 their own separate, private, and distinct living units.

23 Sites for the operation of the program shall be selected

1 by the Department based upon criteria that may include the
2 need for services in a geographic area, the availability of
3 funding, and the site's ability to meet the standards.

4 (b) Beginning July 1, 2014, subject to federal approval,
5 the Medicaid rates for supportive living facilities shall be
6 equal to the supportive living facility Medicaid rate
7 effective on June 30, 2014 increased by 8.85%. Once the
8 assessment imposed at Article V-G of this Code is determined
9 to be a permissible tax under Title XIX of the Social Security
10 Act, the Department shall increase the Medicaid rates for
11 supportive living facilities effective on July 1, 2014 by
12 9.09%. The Department shall apply this increase retroactively
13 to coincide with the imposition of the assessment in Article
14 V-G of this Code in accordance with the approval for federal
15 financial participation by the Centers for Medicare and
16 Medicaid Services.

17 The Medicaid rates for supportive living facilities
18 effective on July 1, 2017 must be equal to the rates in effect
19 for supportive living facilities on June 30, 2017 increased by
20 2.8%.

21 The Medicaid rates for supportive living facilities
22 effective on July 1, 2018 must be equal to the rates in effect
23 for supportive living facilities on June 30, 2018.

24 Subject to federal approval, the Medicaid rates for
25 supportive living services on and after July 1, 2019 must be at
26 least 54.3% of the average total nursing facility services per

1 diem for the geographic areas defined by the Department while
2 maintaining the rate differential for dementia care and must
3 be updated whenever the total nursing facility service per
4 diems are updated. Beginning July 1, 2022, upon the
5 implementation of the Patient Driven Payment Model, Medicaid
6 rates for supportive living services must be at least 54.3% of
7 the average total nursing services per diem rate for the
8 geographic areas. For purposes of this provision, the average
9 total nursing services per diem rate shall include all add-ons
10 for nursing facilities for the geographic area provided for in
11 Section 5-5.2. The rate differential for dementia care must be
12 maintained in these rates and the rates shall be updated
13 whenever nursing facility per diem rates are updated.

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

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

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

5 (2) those distinct parts of the site or building are
6 completely separate from the part of the building used for
7 the provision of supportive living program services,
8 including separate entrances;

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

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

16 (e) Facilities or distinct parts of facilities which are
17 selected as supportive living facilities and are in good
18 standing with the Department's rules are exempt from the
19 provisions of the Nursing Home Care Act and the Illinois
20 Health Facilities Planning Act.

21 (f) Section 9817 of the American Rescue Plan Act of 2021
22 (Public Law 117-2) authorizes a 10% enhanced federal medical
23 assistance percentage for supportive living services for a
24 12-month period from April 1, 2021 through March 31, 2022.
25 Subject to federal approval, including the approval of any
26 necessary waiver amendments or other federally required

1 documents or assurances, for a 12-month period the Department
2 must pay a supplemental \$26 per diem rate to all supportive
3 living facilities with the additional federal financial
4 participation funds that result from the enhanced federal
5 medical assistance percentage from April 1, 2021 through March
6 31, 2022. The Department may issue parameters around how the
7 supplemental payment should be spent, including quality
8 improvement activities. The Department may alter the form,
9 methods, or timeframes concerning the supplemental per diem
10 rate to comply with any subsequent changes to federal law,
11 changes made by guidance issued by the federal Centers for
12 Medicare and Medicaid Services, or other changes necessary to
13 receive the enhanced federal medical assistance percentage.

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

1 supportive living program site in any other county.

2 (Source: P.A. 101-10, eff. 6-5-19; 102-43, eff. 7-6-21;
3 102-699, eff. 4-19-22.)

4 ARTICLE 105.

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

7 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

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

9 Sec. 5A-2. Assessment.

10 (a)(1) Subject to Sections 5A-3 and 5A-10, for State
11 fiscal years 2009 through 2018, or as long as continued under
12 Section 5A-16, an annual assessment on inpatient services is
13 imposed on each hospital provider in an amount equal to
14 \$218.38 multiplied by the difference of the hospital's
15 occupied bed days less the hospital's Medicare bed days,
16 provided, however, that the amount of \$218.38 shall be
17 increased by a uniform percentage to generate an amount equal
18 to 75% of the State share of the payments authorized under
19 Section 5A-12.5, with such increase only taking effect upon
20 the date that a State share for such payments is required under
21 federal law. For the period of April through June 2015, the
22 amount of \$218.38 used to calculate the assessment under this
23 paragraph shall, by emergency rule under subsection (s) of

1 Section 5-45 of the Illinois Administrative Procedure Act, be
2 increased by a uniform percentage to generate \$20,250,000 in
3 the aggregate for that period from all hospitals subject to
4 the annual assessment under this paragraph.

5 (2) In addition to any other assessments imposed under
6 this Article, effective July 1, 2016 and semi-annually
7 thereafter through June 2018, or as provided in Section 5A-16,
8 in addition to any federally required State share as
9 authorized under paragraph (1), the amount of \$218.38 shall be
10 increased by a uniform percentage to generate an amount equal
11 to 75% of the ACA Assessment Adjustment, as defined in
12 subsection (b-6) of this Section.

13 For State fiscal years 2009 through 2018, or as provided
14 in Section 5A-16, a hospital's occupied bed days and Medicare
15 bed days shall be determined using the most recent data
16 available from each hospital's 2005 Medicare cost report as
17 contained in the Healthcare Cost Report Information System
18 file, for the quarter ending on December 31, 2006, without
19 regard to any subsequent adjustments or changes to such data.
20 If a hospital's 2005 Medicare cost report is not contained in
21 the Healthcare Cost Report Information System, then the
22 Illinois Department may obtain the hospital provider's
23 occupied bed days and Medicare bed days from any source
24 available, including, but not limited to, records maintained
25 by the hospital provider, which may be inspected at all times
26 during business hours of the day by the Illinois Department or

1 its duly authorized agents and employees.

2 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
3 fiscal years 2019 and 2020, an annual assessment on inpatient
4 services is imposed on each hospital provider in an amount
5 equal to \$197.19 multiplied by the difference of the
6 hospital's occupied bed days less the hospital's Medicare bed
7 days. For State fiscal years 2019 and 2020, a hospital's
8 occupied bed days and Medicare bed days shall be determined
9 using the most recent data available from each hospital's 2015
10 Medicare cost report as contained in the Healthcare Cost
11 Report Information System file, for the quarter ending on
12 March 31, 2017, without regard to any subsequent adjustments
13 or changes to such data. If a hospital's 2015 Medicare cost
14 report is not contained in the Healthcare Cost Report
15 Information System, then the Illinois Department may obtain
16 the hospital provider's occupied bed days and Medicare bed
17 days from any source available, including, but not limited to,
18 records maintained by the hospital provider, which may be
19 inspected at all times during business hours of the day by the
20 Illinois Department or its duly authorized agents and
21 employees. Notwithstanding any other provision in this
22 Article, for a hospital provider that did not have a 2015
23 Medicare cost report, but paid an assessment in State fiscal
24 year 2018 on the basis of hypothetical data, that assessment
25 amount shall be used for State fiscal years 2019 and 2020.

26 (4) Subject to Sections 5A-3 and 5A-10 and to subsection

1 (b-8), for the period of July 1, 2020 through December 31, 2020
2 and calendar years 2021 through 2026, an annual assessment on
3 inpatient services is imposed on each hospital provider in an
4 amount equal to \$221.50 multiplied by the difference of the
5 hospital's occupied bed days less the hospital's Medicare bed
6 days, provided however: for the period of July 1, 2020 through
7 December 31, 2020, (i) the assessment shall be equal to 50% of
8 the annual amount; and (ii) the amount of \$221.50 shall be
9 retroactively adjusted by a uniform percentage to generate an
10 amount equal to 50% of the Assessment Adjustment, as defined
11 in subsection (b-7). For the period of July 1, 2020 through
12 December 31, 2020 and calendar years 2021 through 2026, a
13 hospital's occupied bed days and Medicare bed days shall be
14 determined using the most recent data available from each
15 hospital's 2015 Medicare cost report as contained in the
16 Healthcare Cost Report Information System file, for the
17 quarter ending on March 31, 2017, without regard to any
18 subsequent adjustments or changes to such data. If a
19 hospital's 2015 Medicare cost report is not contained in the
20 Healthcare Cost Report Information System, then the Illinois
21 Department may obtain the hospital provider's occupied bed
22 days and Medicare bed days from any source available,
23 including, but not limited to, records maintained by the
24 hospital provider, which may be inspected at all times during
25 business hours of the day by the Illinois Department or its
26 duly authorized agents and employees. Should the change in the

1 assessment methodology for fiscal years 2021 through December
2 31, 2022 not be approved on or before June 30, 2020, the
3 assessment and payments under this Article in effect for
4 fiscal year 2020 shall remain in place until the new
5 assessment is approved. If the assessment methodology for July
6 1, 2020 through December 31, 2022, is approved on or after July
7 1, 2020, it shall be retroactive to July 1, 2020, subject to
8 federal approval and provided that the payments authorized
9 under Section 5A-12.7 have the same effective date as the new
10 assessment methodology. In giving retroactive effect to the
11 assessment approved after June 30, 2020, credit toward the new
12 assessment shall be given for any payments of the previous
13 assessment for periods after June 30, 2020. Notwithstanding
14 any other provision of this Article, for a hospital provider
15 that did not have a 2015 Medicare cost report, but paid an
16 assessment in State Fiscal Year 2020 on the basis of
17 hypothetical data, the data that was the basis for the 2020
18 assessment shall be used to calculate the assessment under
19 this paragraph until December 31, 2023. Beginning July 1, 2022
20 and through December 31, 2024, a safety-net hospital that had
21 a change of ownership in calendar year 2021, and whose
22 inpatient utilization had decreased by 90% from the prior year
23 and prior to the change of ownership, may be eligible to pay a
24 tax based on hypothetical data based on a determination of
25 financial distress by the Department. Subject to federal
26 approval, the Department may, by January 1, 2024, develop a

1 hypothetical tax for a specialty cancer hospital which had a
2 structural change of ownership during calendar year 2022 from
3 a for-profit entity to a non-profit entity, and which has
4 experienced a decline of 60% or greater in inpatient days of
5 care as compared to the prior owners 2015 Medicare cost
6 report. This change of ownership may make the hospital
7 eligible for a hypothetical tax under the new hospital
8 provision of the assessment defined in this Section. This new
9 hypothetical tax may be applicable from January 1, 2024
10 through December 31, 2026.

11 (b) (Blank).

12 (b-5) (1) Subject to Sections 5A-3 and 5A-10, for the
13 portion of State fiscal year 2012, beginning June 10, 2012
14 through June 30, 2012, and for State fiscal years 2013 through
15 2018, or as provided in Section 5A-16, an annual assessment on
16 outpatient services is imposed on each hospital provider in an
17 amount equal to .008766 multiplied by the hospital's
18 outpatient gross revenue, provided, however, that the amount
19 of .008766 shall be increased by a uniform percentage to
20 generate an amount equal to 25% of the State share of the
21 payments authorized under Section 5A-12.5, with such increase
22 only taking effect upon the date that a State share for such
23 payments is required under federal law. For the period
24 beginning June 10, 2012 through June 30, 2012, the annual
25 assessment on outpatient services shall be prorated by
26 multiplying the assessment amount by a fraction, the numerator

1 of which is 21 days and the denominator of which is 365 days.
2 For the period of April through June 2015, the amount of
3 .008766 used to calculate the assessment under this paragraph
4 shall, by emergency rule under subsection (s) of Section 5-45
5 of the Illinois Administrative Procedure Act, be increased by
6 a uniform percentage to generate \$6,750,000 in the aggregate
7 for that period from all hospitals subject to the annual
8 assessment under this paragraph.

9 (2) In addition to any other assessments imposed under
10 this Article, effective July 1, 2016 and semi-annually
11 thereafter through June 2018, in addition to any federally
12 required State share as authorized under paragraph (1), the
13 amount of .008766 shall be increased by a uniform percentage
14 to generate an amount equal to 25% of the ACA Assessment
15 Adjustment, as defined in subsection (b-6) of this Section.

16 For the portion of State fiscal year 2012, beginning June
17 10, 2012 through June 30, 2012, and State fiscal years 2013
18 through 2018, or as provided in Section 5A-16, a hospital's
19 outpatient gross revenue shall be determined using the most
20 recent data available from each hospital's 2009 Medicare cost
21 report as contained in the Healthcare Cost Report Information
22 System file, for the quarter ending on June 30, 2011, without
23 regard to any subsequent adjustments or changes to such data.
24 If a hospital's 2009 Medicare cost report is not contained in
25 the Healthcare Cost Report Information System, then the
26 Department may obtain the hospital provider's outpatient gross

1 revenue from any source available, including, but not limited
2 to, records maintained by the hospital provider, which may be
3 inspected at all times during business hours of the day by the
4 Department or its duly authorized agents and employees.

5 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
6 fiscal years 2019 and 2020, an annual assessment on outpatient
7 services is imposed on each hospital provider in an amount
8 equal to .01358 multiplied by the hospital's outpatient gross
9 revenue. For State fiscal years 2019 and 2020, a hospital's
10 outpatient gross revenue shall be determined using the most
11 recent data available from each hospital's 2015 Medicare cost
12 report as contained in the Healthcare Cost Report Information
13 System file, for the quarter ending on March 31, 2017, without
14 regard to any subsequent adjustments or changes to such data.
15 If a hospital's 2015 Medicare cost report is not contained in
16 the Healthcare Cost Report Information System, then the
17 Department may obtain the hospital provider's outpatient gross
18 revenue from any source available, including, but not limited
19 to, records maintained by the hospital provider, which may be
20 inspected at all times during business hours of the day by the
21 Department or its duly authorized agents and employees.
22 Notwithstanding any other provision in this Article, for a
23 hospital provider that did not have a 2015 Medicare cost
24 report, but paid an assessment in State fiscal year 2018 on the
25 basis of hypothetical data, that assessment amount shall be
26 used for State fiscal years 2019 and 2020.

1 (4) Subject to Sections 5A-3 and 5A-10 and to subsection
2 (b-8), for the period of July 1, 2020 through December 31, 2020
3 and calendar years 2021 through 2026, an annual assessment on
4 outpatient services is imposed on each hospital provider in an
5 amount equal to .01525 multiplied by the hospital's outpatient
6 gross revenue, provided however: (i) for the period of July 1,
7 2020 through December 31, 2020, the assessment shall be equal
8 to 50% of the annual amount; and (ii) the amount of .01525
9 shall be retroactively adjusted by a uniform percentage to
10 generate an amount equal to 50% of the Assessment Adjustment,
11 as defined in subsection (b-7). For the period of July 1, 2020
12 through December 31, 2020 and calendar years 2021 through
13 2026, a hospital's outpatient gross revenue shall be
14 determined using the most recent data available from each
15 hospital's 2015 Medicare cost report as contained in the
16 Healthcare Cost Report Information System file, for the
17 quarter ending on March 31, 2017, without regard to any
18 subsequent adjustments or changes to such data. If a
19 hospital's 2015 Medicare cost report is not contained in the
20 Healthcare Cost Report Information System, then the Illinois
21 Department may obtain the hospital provider's outpatient
22 revenue data from any source available, including, but not
23 limited to, records maintained by the hospital provider, which
24 may be inspected at all times during business hours of the day
25 by the Illinois Department or its duly authorized agents and
26 employees. Should the change in the assessment methodology

1 above for fiscal years 2021 through calendar year 2022 not be
2 approved prior to July 1, 2020, the assessment and payments
3 under this Article in effect for fiscal year 2020 shall remain
4 in place until the new assessment is approved. If the change in
5 the assessment methodology above for July 1, 2020 through
6 December 31, 2022, is approved after June 30, 2020, it shall
7 have a retroactive effective date of July 1, 2020, subject to
8 federal approval and provided that the payments authorized
9 under Section 12A-7 have the same effective date as the new
10 assessment methodology. In giving retroactive effect to the
11 assessment approved after June 30, 2020, credit toward the new
12 assessment shall be given for any payments of the previous
13 assessment for periods after June 30, 2020. Notwithstanding
14 any other provision of this Article, for a hospital provider
15 that did not have a 2015 Medicare cost report, but paid an
16 assessment in State Fiscal Year 2020 on the basis of
17 hypothetical data, the data that was the basis for the 2020
18 assessment shall be used to calculate the assessment under
19 this paragraph until December 31, 2023. Beginning July 1, 2022
20 and through December 31, 2024, a safety-net hospital that had
21 a change of ownership in calendar year 2021, and whose
22 inpatient utilization had decreased by 90% from the prior year
23 and prior to the change of ownership, may be eligible to pay a
24 tax based on hypothetical data based on a determination of
25 financial distress by the Department.

26 (b-6) (1) As used in this Section, "ACA Assessment

1 Adjustment" means:

2 (A) For the period of July 1, 2016 through December
3 31, 2016, the product of .19125 multiplied by the sum of
4 the fee-for-service payments to hospitals as authorized
5 under Section 5A-12.5 and the adjustments authorized under
6 subsection (t) of Section 5A-12.2 to managed care
7 organizations for hospital services due and payable in the
8 month of April 2016 multiplied by 6.

9 (B) For the period of January 1, 2017 through June 30,
10 2017, the product of .19125 multiplied by the sum of the
11 fee-for-service payments to hospitals as authorized under
12 Section 5A-12.5 and the adjustments authorized under
13 subsection (t) of Section 5A-12.2 to managed care
14 organizations for hospital services due and payable in the
15 month of October 2016 multiplied by 6, except that the
16 amount calculated under this subparagraph (B) shall be
17 adjusted, either positively or negatively, to account for
18 the difference between the actual payments issued under
19 Section 5A-12.5 for the period beginning July 1, 2016
20 through December 31, 2016 and the estimated payments due
21 and payable in the month of April 2016 multiplied by 6 as
22 described in subparagraph (A).

23 (C) For the period of July 1, 2017 through December
24 31, 2017, the product of .19125 multiplied by the sum of
25 the fee-for-service payments to hospitals as authorized
26 under Section 5A-12.5 and the adjustments authorized under

1 subsection (t) of Section 5A-12.2 to managed care
2 organizations for hospital services due and payable in the
3 month of April 2017 multiplied by 6, except that the
4 amount calculated under this subparagraph (C) shall be
5 adjusted, either positively or negatively, to account for
6 the difference between the actual payments issued under
7 Section 5A-12.5 for the period beginning January 1, 2017
8 through June 30, 2017 and the estimated payments due and
9 payable in the month of October 2016 multiplied by 6 as
10 described in subparagraph (B).

11 (D) For the period of January 1, 2018 through June 30,
12 2018, the product of .19125 multiplied by the sum of the
13 fee-for-service payments to hospitals as authorized under
14 Section 5A-12.5 and the adjustments authorized under
15 subsection (t) of Section 5A-12.2 to managed care
16 organizations for hospital services due and payable in the
17 month of October 2017 multiplied by 6, except that:

18 (i) the amount calculated under this subparagraph

19 (D) shall be adjusted, either positively or
20 negatively, to account for the difference between the
21 actual payments issued under Section 5A-12.5 for the
22 period of July 1, 2017 through December 31, 2017 and
23 the estimated payments due and payable in the month of
24 April 2017 multiplied by 6 as described in
25 subparagraph (C); and

26 (ii) the amount calculated under this subparagraph

1 (D) shall be adjusted to include the product of .19125
2 multiplied by the sum of the fee-for-service payments,
3 if any, estimated to be paid to hospitals under
4 subsection (b) of Section 5A-12.5.

5 (2) The Department shall complete and apply a final
6 reconciliation of the ACA Assessment Adjustment prior to June
7 30, 2018 to account for:

8 (A) any differences between the actual payments issued
9 or scheduled to be issued prior to June 30, 2018 as
10 authorized in Section 5A-12.5 for the period of January 1,
11 2018 through June 30, 2018 and the estimated payments due
12 and payable in the month of October 2017 multiplied by 6 as
13 described in subparagraph (D); and

14 (B) any difference between the estimated
15 fee-for-service payments under subsection (b) of Section
16 5A-12.5 and the amount of such payments that are actually
17 scheduled to be paid.

18 The Department shall notify hospitals of any additional
19 amounts owed or reduction credits to be applied to the June
20 2018 ACA Assessment Adjustment. This is to be considered the
21 final reconciliation for the ACA Assessment Adjustment.

22 (3) Notwithstanding any other provision of this Section,
23 if for any reason the scheduled payments under subsection (b)
24 of Section 5A-12.5 are not issued in full by the final day of
25 the period authorized under subsection (b) of Section 5A-12.5,
26 funds collected from each hospital pursuant to subparagraph

1 (D) of paragraph (1) and pursuant to paragraph (2),
2 attributable to the scheduled payments authorized under
3 subsection (b) of Section 5A-12.5 that are not issued in full
4 by the final day of the period attributable to each payment
5 authorized under subsection (b) of Section 5A-12.5, shall be
6 refunded.

7 (4) The increases authorized under paragraph (2) of
8 subsection (a) and paragraph (2) of subsection (b-5) shall be
9 limited to the federally required State share of the total
10 payments authorized under Section 5A-12.5 if the sum of such
11 payments yields an annualized amount equal to or less than
12 \$450,000,000, or if the adjustments authorized under
13 subsection (t) of Section 5A-12.2 are found not to be
14 actuarially sound; however, this limitation shall not apply to
15 the fee-for-service payments described in subsection (b) of
16 Section 5A-12.5.

17 (b-7)(1) As used in this Section, "Assessment Adjustment"
18 means:

19 (A) For the period of July 1, 2020 through December
20 31, 2020, the product of .3853 multiplied by the total of
21 the actual payments made under subsections (c) through (k)
22 of Section 5A-12.7 attributable to the period, less the
23 total of the assessment imposed under subsections (a) and
24 (b-5) of this Section for the period.

25 (B) For each calendar quarter beginning January 1,
26 2021 through December 31, 2022, the product of .3853

1 multiplied by the total of the actual payments made under
2 subsections (c) through (k) of Section 5A-12.7
3 attributable to the period, less the total of the
4 assessment imposed under subsections (a) and (b-5) of this
5 Section for the period.

6 (C) Beginning on January 1, 2023, and each subsequent
7 July 1 and January 1, the product of .3853 multiplied by
8 the total of the actual payments made under subsections
9 (c) through (j) of Section 5A-12.7 attributable to the
10 6-month period immediately preceding the period to which
11 the adjustment applies, less the total of the assessment
12 imposed under subsections (a) and (b-5) of this Section
13 for the 6-month period immediately preceding the period to
14 which the adjustment applies.

15 (2) The Department shall calculate and notify each
16 hospital of the total Assessment Adjustment and any additional
17 assessment owed by the hospital or refund owed to the hospital
18 on either a semi-annual or annual basis. Such notice shall be
19 issued at least 30 days prior to any period in which the
20 assessment will be adjusted. Any additional assessment owed by
21 the hospital or refund owed to the hospital shall be uniformly
22 applied to the assessment owed by the hospital in monthly
23 installments for the subsequent semi-annual period or calendar
24 year. If no assessment is owed in the subsequent year, any
25 amount owed by the hospital or refund due to the hospital,
26 shall be paid in a lump sum.

1 (3) The Department shall publish all details of the
2 Assessment Adjustment calculation performed each year on its
3 website within 30 days of completing the calculation, and also
4 submit the details of the Assessment Adjustment calculation as
5 part of the Department's annual report to the General
6 Assembly.

7 (b-8) Notwithstanding any other provision of this Article,
8 the Department shall reduce the assessments imposed on each
9 hospital under subsections (a) and (b-5) by the uniform
10 percentage necessary to reduce the total assessment imposed on
11 all hospitals by an aggregate amount of \$240,000,000, with
12 such reduction being applied by June 30, 2022. The assessment
13 reduction required for each hospital under this subsection
14 shall be forever waived, forgiven, and released by the
15 Department.

16 (c) (Blank).

17 (d) Notwithstanding any of the other provisions of this
18 Section, the Department is authorized to adopt rules to reduce
19 the rate of any annual assessment imposed under this Section,
20 as authorized by Section 5-46.2 of the Illinois Administrative
21 Procedure Act.

22 (e) Notwithstanding any other provision of this Section,
23 any plan providing for an assessment on a hospital provider as
24 a permissible tax under Title XIX of the federal Social
25 Security Act and Medicaid-eligible payments to hospital
26 providers from the revenues derived from that assessment shall

1 be reviewed by the Illinois Department of Healthcare and
2 Family Services, as the Single State Medicaid Agency required
3 by federal law, to determine whether those assessments and
4 hospital provider payments meet federal Medicaid standards. If
5 the Department determines that the elements of the plan may
6 meet federal Medicaid standards and a related State Medicaid
7 Plan Amendment is prepared in a manner and form suitable for
8 submission, that State Plan Amendment shall be submitted in a
9 timely manner for review by the Centers for Medicare and
10 Medicaid Services of the United States Department of Health
11 and Human Services and subject to approval by the Centers for
12 Medicare and Medicaid Services of the United States Department
13 of Health and Human Services. No such plan shall become
14 effective without approval by the Illinois General Assembly by
15 the enactment into law of related legislation. Notwithstanding
16 any other provision of this Section, the Department is
17 authorized to adopt rules to reduce the rate of any annual
18 assessment imposed under this Section. Any such rules may be
19 adopted by the Department under Section 5-50 of the Illinois
20 Administrative Procedure Act.

21 (Source: P.A. 101-10, eff. 6-5-19; 101-650, eff. 7-7-20;
22 reenacted by P.A. 101-655, eff. 3-12-21; 102-886, eff.
23 5-17-22.)

24 ARTICLE 110.

1 Section 110-5. The Illinois Insurance Code is amended by
2 adding Section 513b7 as follows:

3 (215 ILCS 5/513b7 new)

4 Sec. 513b7. Pharmacy audits.

5 (a) As used in this Section:

6 "Audit" means any physical on-site, remote electronic, or
7 concurrent review of a pharmacist or pharmacy service
8 submitted to the pharmacy benefit manager or pharmacy benefit
9 manager affiliate by a pharmacist or pharmacy for payment.

10 "Auditing entity" means a person or company that performs
11 a pharmacy audit.

12 "Extrapolation" means the practice of inferring a
13 frequency of dollar amount of overpayments, underpayments,
14 nonvalid claims, or other errors on any portion of claims
15 submitted, based on the frequency of dollar amount of
16 overpayments, underpayments, nonvalid claims, or other errors
17 actually measured in a sample of claims.

18 "Misfill" means a prescription that was not dispensed; a
19 prescription that was dispensed but was an incorrect dose,
20 amount, or type of medication; a prescription that was
21 dispensed to the wrong person; a prescription in which the
22 prescriber denied the authorization request; or a prescription
23 in which an additional dispensing fee was charged.

24 "Pharmacy audit" means an audit conducted of any records
25 of a pharmacy for prescriptions dispensed or nonproprietary

1 drugs or pharmacist services provided by a pharmacy or
2 pharmacist to a covered person.

3 "Pharmacy record" means any record stored electronically
4 or as a hard copy by a pharmacy that relates to the provision
5 of a prescription or pharmacy services or other component of
6 pharmacist care that is included in the practice of pharmacy.

7 (b) Notwithstanding any other law, when conducting a
8 pharmacy audit, an auditing entity shall:

9 (1) not conduct an on-site audit of a pharmacy at any
10 time during the first 3 business days of a month or the
11 first 2 weeks and final 2 weeks of the calendar year or
12 during a declared State or federal public health
13 emergency;

14 (2) notify the pharmacy or its contracting agent no
15 later than 14 business days before the date of initial
16 on-site audit; the notification to the pharmacy or its
17 contracting agent shall be in writing and delivered
18 either:

19 (A) by mail or common carrier, return receipt
20 requested; or

21 (B) electronically, not including facsimile, with
22 electronic receipt confirmation and delivered during
23 normal business hours of operation, addressed to the
24 supervising pharmacist and pharmacy corporate office,
25 if applicable, at least 14 business days before the
26 date of an initial on-site audit;

1 (3) limit the audit period to 24 months after the date
2 a claim is submitted to or adjudicated by the pharmacy
3 benefit manager;

4 (4) provide in writing the list of specific
5 prescription numbers to be included in the audit 14
6 business days before the on-site audit that may or may not
7 include the final 2 digits of the prescription numbers;

8 (5) use the written and verifiable records of a
9 hospital, physician, or other authorized practitioner that
10 are transmitted by any means of communication to validate
11 the pharmacy records in accordance with State and federal
12 law;

13 (6) limit the number of prescriptions audited to no
14 more than 100 prescriptions per audit and an entity shall
15 not audit more than 200 prescriptions in any 12-month
16 period, except in cases of fraud or knowing and willful
17 misrepresentation; a refill shall not constitute a
18 separate prescription and a pharmacy shall not be audited
19 more than once every 6 months;

20 (7) provide the pharmacy or its contracting agent with
21 a copy of the preliminary audit report within 45 days
22 after the conclusion of the audit;

23 (8) be allowed to conduct a follow-up audit on site if
24 a remote or desk audit reveals the necessity for a review
25 of additional claims;

26 (9) accept invoice audits as validation invoices from

1 any wholesaler registered with the Department of Financial
2 and Professional Regulation from which the pharmacy has
3 purchased prescription drugs or, in the case of durable
4 medical equipment or sickroom supplies, invoices from an
5 authorized distributor other than a wholesaler;

6 (10) provide the pharmacy or its contracting agent
7 with the ability to provide documentation to address a
8 discrepancy or audit finding if the documentation is
9 received by the pharmacy benefit manager no later than the
10 45th day after the preliminary audit report was provided
11 to the pharmacy or its contracting agent; the pharmacy
12 benefit manager shall consider a reasonable request from
13 the pharmacy for an extension of time to submit
14 documentation to address or correct any findings in the
15 report;

16 (11) be required to provide the pharmacy or its
17 contracting agent with the final audit report no later
18 than 90 days after the initial audit report was provided
19 to the pharmacy or its contracting agent;

20 (12) conduct the audit in consultation with a
21 pharmacist in specific cases if the audit involves
22 clinical or professional judgment;

23 (13) not chargeback, recoup, or collect penalties from
24 a pharmacy until the time period to file an appeal of the
25 final pharmacy audit report has passed or the appeals
26 process has been exhausted, whichever is later, unless the

1 identified discrepancy is expected to exceed \$25,000, in
2 which case the auditing entity may withhold future
3 payments in excess of that amount until the final
4 resolution of the audit;

5 (14) not compensate the employee or contractor
6 conducting the audit based on a percentage of the amount
7 claimed or recouped pursuant to the audit;

8 (15) not use extrapolation to calculate penalties or
9 amounts to be charged back or recouped unless otherwise
10 required by federal law or regulation; any amount to be
11 charged back or recouped due to overpayment may not exceed
12 the amount the pharmacy was overpaid;

13 (16) not include dispensing fees in the calculation of
14 overpayments unless a prescription is considered a
15 misfill, the medication is not delivered to the patient,
16 the prescription is not valid, or the prescriber denies
17 authorizing the prescription; and

18 (17) conduct a pharmacy audit under the same standards
19 and parameters as conducted for other similarly situated
20 pharmacies audited by the auditing entity.

21 (c) Except as otherwise provided by State or federal law,
22 an auditing entity conducting a pharmacy audit may have access
23 to a pharmacy's previous audit report only if the report was
24 prepared by that auditing entity.

25 (d) Information collected during a pharmacy audit shall be
26 confidential by law, except that the auditing entity

1 conducting the pharmacy audit may share the information with
2 the health benefit plan for which a pharmacy audit is being
3 conducted and with any regulatory agencies and law enforcement
4 agencies as required by law.

5 (e) A pharmacy may not be subject to a chargeback or
6 recoupment for a clerical or recordkeeping error in a required
7 document or record, including a typographical error or
8 computer error, unless the pharmacy benefit manager can
9 provide proof of intent to commit fraud or such error results
10 in actual financial harm to the pharmacy benefit manager, a
11 health plan managed by the pharmacy benefit manager, or a
12 consumer.

13 (f) A pharmacy shall have the right to file a written
14 appeal of a preliminary and final pharmacy audit report in
15 accordance with the procedures established by the entity
16 conducting the pharmacy audit.

17 (g) No interest shall accrue for any party during the
18 audit period, beginning with the notice of the pharmacy audit
19 and ending with the conclusion of the appeals process.

20 (h) An auditing entity must provide a copy to the plan
21 sponsor of its claims that were included in the audit, and any
22 recouped money shall be returned to the plan sponsor, unless
23 otherwise contractually agreed upon by the plan sponsor and
24 the pharmacy benefit manager.

25 (i) The parameters of an audit must comply with
26 manufacturer listings or recommendations, unless otherwise

1 prescribed by the treating provider, and must be covered under
2 the individual's health plan, for the following:

3 (1) the day supply for eye drops must be calculated so
4 that the consumer pays only one 30-day copayment if the
5 bottle of eye drops is intended by the manufacturer to be a
6 30-day supply;

7 (2) the day supply for insulin must be calculated so
8 that the highest dose prescribed is used to determine the
9 day supply and consumer copayment; and

10 (3) the day supply for topical product must be
11 determined by the judgment of the pharmacist or treating
12 provider upon the treated area.

13 (j) This Section shall not apply to:

14 (1) audits in which suspected fraud or knowing and
15 willful misrepresentation is evidenced by a physical
16 review, review of claims data or statements, or other
17 investigative methods;

18 (2) audits of claims paid for by federally funded
19 programs not applicable to health insurance coverage
20 regulated by the Department; or

21 (3) concurrent reviews or desk audits that occur
22 within 3 business days after transmission of a claim and
23 in which no chargeback or recoupment is demanded.

1 Section 115-5. The Illinois Public Aid Code is amended by
2 changing Section 5-30.11 as follows:

3 (305 ILCS 5/5-30.11)

4 Sec. 5-30.11. Treatment of autism spectrum disorder.
5 Treatment of autism spectrum disorder through applied behavior
6 analysis shall be covered under the medical assistance program
7 under this Article for children with a diagnosis of autism
8 spectrum disorder when (1) ordered by:~~(1)~~ a physician
9 licensed to practice medicine in all its branches or a
10 psychologist licensed by the Department of Financial and
11 Professional Regulation and (2) and rendered by a licensed or
12 ~~certified health care professional with expertise in applied~~
13 ~~behavior analysis; or (2) when~~ evaluated ~~and treated~~ by a
14 behavior analyst as recognized by the Department or licensed
15 by the Department of Financial and Professional Regulation to
16 practice applied behavior analysis in this State. Such
17 coverage may be limited to age ranges based on evidence-based
18 best practices. Appropriate State plan amendments as well as
19 rules regarding provision of services and providers will be
20 submitted by September 1, 2019. Pursuant to the flexibilities
21 allowed by the federal Centers for Medicare and Medicaid
22 Services to Illinois under the Medical Assistance Program, the
23 Department shall enroll and reimburse qualified staff to
24 perform applied behavior analysis services in advance of
25 Illinois licensure activities performed by the Department of

1 Financial and Professional Regulation. These services shall be
2 covered if they are provided in a home or community setting or
3 in an office-based setting. The Department may conduct annual
4 on-site reviews of the services authorized under this Section.
5 Provider enrollment shall occur no later than September 1,
6 2023.

7 (Source: P.A. 101-10, eff. 6-5-19; 102-558, eff. 8-20-21;
8 102-953, eff. 5-27-22.)

9 ARTICLE 120.

10 Section 120-5. The Illinois Public Aid Code is amended by
11 adding Section 5-5a.1 as follows:

12 (305 ILCS 5/5-5a.1 new)

13 Sec. 5-5a.1. Telehealth services for persons with
14 intellectual and developmental disabilities. The Department
15 shall file an amendment to the Home and Community-Based
16 Services Waiver Program for Adults with Developmental
17 Disabilities authorized under Section 1915(c) of the Social
18 Security Act to incorporate telehealth services administered
19 by a provider of telehealth services that demonstrates
20 knowledge and experience in providing medical and emergency
21 services for persons with intellectual and developmental
22 disabilities. The Department shall pay administrative fees
23 associated with implementing telehealth services for all

1 persons with intellectual and developmental disabilities who
2 are receiving services under the Home and Community-Based
3 Services Waiver Program for Adults with Developmental
4 Disabilities.

5 ARTICLE 125.

6 Section 125-5. The Illinois Public Aid Code is amended by
7 adding Section 5-48 as follows:

8 (305 ILCS 5/5-48 new)

9 Sec. 5-48. Increasing behavioral health service capacity
10 in federally qualified health centers. The Department of
11 Healthcare and Family Services shall develop policies and
12 procedures with the goal of increasing the capacity of
13 behavioral health services provided by federally qualified
14 health centers as defined in Section 1905(1)(2)(B) of the
15 federal Social Security Act. Subject to federal approval, the
16 Department shall develop, no later than January 1, 2024,
17 billing policies that provide reimbursement to federally
18 qualified health centers for services rendered by
19 graduate-level, sub-clinical behavioral health professionals
20 who deliver care under the supervision of a fully licensed
21 behavioral health clinician who is licensed as a clinical
22 social worker, clinical professional counselor, marriage and
23 family therapist, or clinical psychologist.

1 (215 ILCS 5/363) (from Ch. 73, par. 975)

2 Sec. 363. Medicare supplement policies; minimum standards.

3 (1) Except as otherwise specifically provided therein,
4 this Section and Section 363a of this Code shall apply to:

5 (a) all Medicare supplement policies and subscriber
6 contracts delivered or issued for delivery in this State
7 on and after January 1, 1989; and

8 (b) all certificates issued under group Medicare
9 supplement policies or subscriber contracts, which
10 certificates are issued or issued for delivery in this
11 State on and after January 1, 1989.

12 This Section shall not apply to "Accident Only" or
13 "Specified Disease" types of policies. The provisions of this
14 Section are not intended to prohibit or apply to policies or
15 health care benefit plans, including group conversion
16 policies, provided to Medicare eligible persons, which
17 policies or plans are not marketed or purported or held to be
18 Medicare supplement policies or benefit plans.

19 (2) For the purposes of this Section and Section 363a, the
20 following terms have the following meanings:

21 (a) "Applicant" means:

22 (i) in the case of individual Medicare supplement
23 policy, the person who seeks to contract for insurance
24 benefits, and

25 (ii) in the case of a group Medicare policy or

1 subscriber contract, the proposed certificate holder.

2 (b) "Certificate" means any certificate delivered or
3 issued for delivery in this State under a group Medicare
4 supplement policy.

5 (c) "Medicare supplement policy" means an individual
6 policy of accident and health insurance, as defined in
7 paragraph (a) of subsection (2) of Section 355a of this
8 Code, or a group policy or certificate delivered or issued
9 for delivery in this State by an insurer, fraternal
10 benefit society, voluntary health service plan, or health
11 maintenance organization, other than a policy issued
12 pursuant to a contract under Section 1876 of the federal
13 Social Security Act (42 U.S.C. Section 1395 et seq.) or a
14 policy issued under a demonstration project specified in
15 42 U.S.C. Section 1395ss(g)(1), or any similar
16 organization, that is advertised, marketed, or designed
17 primarily as a supplement to reimbursements under Medicare
18 for the hospital, medical, or surgical expenses of persons
19 eligible for Medicare.

20 (d) "Issuer" includes insurance companies, fraternal
21 benefit societies, voluntary health service plans, health
22 maintenance organizations, or any other entity providing
23 Medicare supplement insurance, unless the context clearly
24 indicates otherwise.

25 (e) "Medicare" means the Health Insurance for the Aged
26 Act, Title XVIII of the Social Security Amendments of

1 1965.

2 (3) No Medicare supplement insurance policy, contract, or
3 certificate, that provides benefits that duplicate benefits
4 provided by Medicare, shall be issued or issued for delivery
5 in this State after December 31, 1988. No such policy,
6 contract, or certificate shall provide lesser benefits than
7 those required under this Section or the existing Medicare
8 Supplement Minimum Standards Regulation, except where
9 duplication of Medicare benefits would result.

10 (4) Medicare supplement policies or certificates shall
11 have a notice prominently printed on the first page of the
12 policy or attached thereto stating in substance that the
13 policyholder or certificate holder shall have the right to
14 return the policy or certificate within 30 days of its
15 delivery and to have the premium refunded directly to him or
16 her in a timely manner if, after examination of the policy or
17 certificate, the insured person is not satisfied for any
18 reason.

19 (5) A Medicare supplement policy or certificate may not
20 deny a claim for losses incurred more than 6 months from the
21 effective date of coverage for a preexisting condition. The
22 policy may not define a preexisting condition more
23 restrictively than a condition for which medical advice was
24 given or treatment was recommended by or received from a
25 physician within 6 months before the effective date of
26 coverage.

1 (6) An issuer of a Medicare supplement policy shall:

2 (a) not deny coverage to an applicant under 65 years
3 of age who meets any of the following criteria:

4 (i) becomes eligible for Medicare by reason of
5 disability if the person makes application for a
6 Medicare supplement policy within 6 months of the
7 first day on which the person enrolls for benefits
8 under Medicare Part B; for a person who is
9 retroactively enrolled in Medicare Part B due to a
10 retroactive eligibility decision made by the Social
11 Security Administration, the application must be
12 submitted within a 6-month period beginning with the
13 month in which the person received notice of
14 retroactive eligibility to enroll;

15 (ii) has Medicare and an employer group health
16 plan (either primary or secondary to Medicare) that
17 terminates or ceases to provide all such supplemental
18 health benefits;

19 (iii) is insured by a Medicare Advantage plan that
20 includes a Health Maintenance Organization, a
21 Preferred Provider Organization, and a Private
22 Fee-For-Service or Medicare Select plan and the
23 applicant moves out of the plan's service area; the
24 insurer goes out of business, withdraws from the
25 market, or has its Medicare contract terminated; or
26 the plan violates its contract provisions or is

1 misrepresented in its marketing; or

2 (iv) is insured by a Medicare supplement policy
3 and the insurer goes out of business, withdraws from
4 the market, or the insurance company or agents
5 misrepresent the plan and the applicant is without
6 coverage;

7 (b) make available to persons eligible for Medicare by
8 reason of disability each type of Medicare supplement
9 policy the issuer makes available to persons eligible for
10 Medicare by reason of age;

11 (c) not charge individuals who become eligible for
12 Medicare by reason of disability and who are under the age
13 of 65 premium rates for any medical supplemental insurance
14 benefit plan offered by the issuer that exceed the
15 issuer's highest rate on the current rate schedule filed
16 with the Division of Insurance for that plan to
17 individuals who are age 65 or older; and

18 (d) provide the rights granted by items (a) through
19 (d), for 6 months after the effective date of this
20 amendatory Act of the 95th General Assembly, to any person
21 who had enrolled for benefits under Medicare Part B prior
22 to this amendatory Act of the 95th General Assembly who
23 otherwise would have been eligible for coverage under item
24 (a).

25 (7) The Director shall issue reasonable rules and
26 regulations for the following purposes:

1 (a) To establish specific standards for policy
2 provisions of Medicare policies and certificates. The
3 standards shall be in accordance with the requirements of
4 this Code. No requirement of this Code relating to minimum
5 required policy benefits, other than the minimum standards
6 contained in this Section and Section 363a, shall apply to
7 Medicare supplement policies and certificates. The
8 standards may cover, but are not limited to the following:

9 (A) Terms of renewability.

10 (B) Initial and subsequent terms of eligibility.

11 (C) Non-duplication of coverage.

12 (D) Probationary and elimination periods.

13 (E) Benefit limitations, exceptions and
14 reductions.

15 (F) Requirements for replacement.

16 (G) Recurrent conditions.

17 (H) Definition of terms.

18 (I) Requirements for issuing rebates or credits to
19 policyholders if the policy's loss ratio does not
20 comply with subsection (7) of Section 363a.

21 (J) Uniform methodology for the calculating and
22 reporting of loss ratio information.

23 (K) Assuring public access to loss ratio
24 information of an issuer of Medicare supplement
25 insurance.

26 (L) Establishing a process for approving or

1 disapproving proposed premium increases.

2 (M) Establishing a policy for holding public
3 hearings prior to approval of premium increases.

4 (N) Establishing standards for Medicare Select
5 policies.

6 (O) Prohibited policy provisions not otherwise
7 specifically authorized by statute that, in the
8 opinion of the Director, are unjust, unfair, or
9 unfairly discriminatory to any person insured or
10 proposed for coverage under a medicare supplement
11 policy or certificate.

12 (b) To establish minimum standards for benefits and
13 claims payments, marketing practices, compensation
14 arrangements, and reporting practices for Medicare
15 supplement policies.

16 (c) To implement transitional requirements of Medicare
17 supplement insurance benefits and premiums of Medicare
18 supplement policies and certificates to conform to
19 Medicare program revisions.

20 (8) If an individual is at least 65 years of age but no
21 more than 75 years of age and has an existing Medicare
22 supplement policy, the individual is entitled to an annual
23 open enrollment period lasting 45 days, commencing with the
24 individual's birthday, and the individual may purchase any
25 Medicare supplement policy with the same issuer that offers
26 benefits equal to or lesser than those provided by the

1 previous coverage. During this open enrollment period, an
2 issuer of a Medicare supplement policy shall not deny or
3 condition the issuance or effectiveness of Medicare
4 supplemental coverage, nor discriminate in the pricing of
5 coverage, because of health status, claims experience, receipt
6 of health care, or a medical condition of the individual. An
7 issuer shall provide notice of this annual open enrollment
8 period for eligible Medicare supplement policyholders at the
9 time that the application is made for a Medicare supplement
10 policy or certificate. The notice shall be in a form that may
11 be prescribed by the Department.

12 (9) Without limiting an individual's eligibility under
13 Department rules implementing 42 U.S.C. 1395ss(s)(2)(A), for
14 at least 63 days after the later of the applicant's loss of
15 benefits or the notice of termination of benefits, including a
16 notice of claim denial due to termination of benefits, under
17 the State's medical assistance program under Article V of the
18 Illinois Public Aid Code, an issuer shall not deny or
19 condition the issuance or effectiveness of any Medicare
20 supplement policy or certificate that is offered and is
21 available for issuance to new enrollees by the issuer; shall
22 not discriminate in the pricing of such a Medicare supplement
23 policy because of health status, claims experience, receipt of
24 health care, or medical condition; and shall not include a
25 policy provision that imposes an exclusion of benefits based
26 on a preexisting condition under such a Medicare supplement

1 policy if the individual:

2 (a) is enrolled for Medicare Part B;

3 (b) was enrolled in the State's medical assistance
4 program during the COVID-19 Public Health Emergency
5 described in Section 5-1.5 of the Illinois Public Aid
6 Code;

7 (c) was terminated or disenrolled from the State's
8 medical assistance program after the COVID-19 Public
9 Health Emergency and the later of the date of termination
10 of benefits or the date of the notice of termination,
11 including a notice of a claim denial due to termination,
12 occurred on, after, or no more than 63 days before the end
13 of either, as applicable:

14 (A) the individual's Medicare supplement open
15 enrollment period described in Department rules
16 implementing 42 U.S.C. 1395ss(s) (2) (A); or

17 (B) the 6-month period described in Section
18 363(6) (a) (i) of this Code; and

19 (d) submits evidence of the date of termination of
20 benefits or notice of termination under the State's
21 medical assistance program with the application for a
22 Medicare supplement policy or certificate.

23 (10) Each Medicare supplement policy and certificate
24 available from an insurer on and after the effective date of
25 this amendatory Act of the 103rd General Assembly shall be
26 made available to all applicants who qualify under

1 subparagraph (i) of paragraph (a) of subsection (6) or
2 Department rules implementing 42 U.S.C. 1395ss(s)(2)(A)
3 without regard to age or applicability of a Medicare Part B
4 late enrollment penalty.

5 (Source: P.A. 102-142, eff. 1-1-22.)

6 ARTICLE 135.

7 Section 135-5. The Illinois Public Aid Code is amended by
8 adding Section 5-49 as follows:

9 (305 ILCS 5/5-49 new)

10 Sec. 5-49. Long-acting reversible contraception. Subject
11 to federal approval, the Department shall adopt policies and
12 rates for long-acting reversible contraception by January 1,
13 2024 to ensure that reimbursement is not reduced by 4.4% below
14 list price. The Department shall submit any necessary
15 application to the federal Centers for Medicare and Medicaid
16 Services for the purposes of implementing such policies and
17 rates.

18 ARTICLE 140.

19 Section 140-5. The Illinois Public Aid Code is amended by
20 changing Section 5-30.8 as follows:

1 (305 ILCS 5/5-30.8)

2 Sec. 5-30.8. Managed care organization rate transparency.

3 (a) For the establishment of managed care organization
4 (MCO) capitation base rate payments from the State, including,
5 but not limited to: (i) hospital fee schedule reforms and
6 updates, (ii) rates related to a single State-mandated
7 preferred drug list, (iii) rate updates related to the State's
8 preferred drug list, (iv) inclusion of coverage for children
9 with special needs, (v) inclusion of coverage for children
10 within the child welfare system, (vi) annual MCO capitation
11 rates, and (vii) any retroactive provider fee schedule
12 adjustments or other changes required by legislation or other
13 actions, the Department of Healthcare and Family Services
14 shall implement a capitation base rate setting process
15 beginning on July 27, 2018 (the effective date of Public Act
16 100-646) which shall include all of the following elements of
17 transparency:

18 (1) The Department shall include participating MCOs
19 and a statewide trade association representing a majority
20 of participating MCOs in meetings to discuss the impact to
21 base capitation rates as a result of any new or updated
22 hospital fee schedules or other provider fee schedules.
23 Additionally, the Department shall share any data or
24 reports used to develop MCO capitation rates with
25 participating MCOs. This data shall be comprehensive
26 enough for MCO actuaries to recreate and verify the

1 accuracy of the capitation base rate build-up.

2 (2) The Department shall not limit the number of
3 experts that each MCO is allowed to bring to the draft
4 capitation base rate meeting or the final capitation base
5 rate review meeting. Draft and final capitation base rate
6 review meetings shall be held in at least 2 locations.

7 (3) The Department and its contracted actuary shall
8 meet with all participating MCOs simultaneously and
9 together along with consulting actuaries contracted with
10 statewide trade association representing a majority of
11 Medicaid health plans at the request of the plans.
12 Participating MCOs shall additionally, at their request,
13 be granted individual capitation rate development meetings
14 with the Department.

15 (4) (Blank). ~~Any quality incentive or other incentive~~
16 ~~withholding of any portion of the actuarially certified~~
17 ~~capitation rates must be budget neutral. The entirety of~~
18 ~~any aggregate withheld amounts must be returned to the~~
19 ~~MCOs in proportion to their performance on the relevant~~
20 ~~performance metric. No amounts shall be returned to the~~
21 ~~Department if all performance measures are not achieved to~~
22 ~~the extent allowable by federal law and regulations.~~

23 (4.5) Effective for calendar year 2024, a quality
24 withhold program may be established by the Department for
25 the HealthChoice Illinois Managed Care Program or any
26 successor program. If such program withholds a portion of

1 the actuarially certified capitation rates, the program
2 must meet the following criteria: (i) benchmarks must be
3 discussed publicly, based on predetermined quality
4 standards that align with the Department's federally
5 approved quality strategy, and set by publication on the
6 Department's website at least 4 months prior to the start
7 of the calendar year; (ii) incentive measures and
8 benchmarks must be reasonable and attainable within the
9 measurement year; and (iii) no less than 75% of the
10 metrics shall be tied to nationally recognized measures.
11 Any non-nationally recognized measures shall be in the
12 reporting category for at least 2 years of experience and
13 evaluation for consistency among MCOs prior to setting a
14 performance baseline. The Department shall provide MCOs
15 with biannual industry average data on the quality
16 withhold measures. If all the money withheld is not earned
17 back by individual MCOs, the Department shall reallocate
18 unearned funds among the MCOs in one or both of the
19 following manners: based upon their quality performance or
20 for quality and equity improvement projects. Nothing in
21 this paragraph prohibits the Department and the MCOs from
22 establishing any other quality performance program.

23 (5) Upon request, the Department shall provide written
24 responses to questions regarding MCO capitation base
25 rates, the capitation base development methodology, and
26 MCO capitation rate data, and all other requests regarding

1 capitation rates from MCOs. Upon request, the Department
2 shall also provide to the MCOs materials used in
3 incorporating provider fee schedules into base capitation
4 rates.

5 (b) For the development of capitation base rates for new
6 capitation rate years:

7 (1) The Department shall take into account emerging
8 experience in the development of the annual MCO capitation
9 base rates, including, but not limited to, current-year
10 cost and utilization trends observed by MCOs in an
11 actuarially sound manner and in accordance with federal
12 law and regulations.

13 (2) No later than January 1 of each year, the
14 Department shall release an agreed upon annual calendar
15 that outlines dates for capitation rate setting meetings
16 for that year. The calendar shall include at least the
17 following meetings and deadlines:

18 (A) An initial meeting for the Department to
19 review MCO data and draft rate assumptions to be used
20 in the development of capitation base rates for the
21 following year.

22 (B) A draft rate meeting after the Department
23 provides the MCOs with the draft capitation base rates
24 to discuss, review, and seek feedback regarding the
25 draft capitation base rates.

26 (3) Prior to the submission of final capitation rates

1 to the federal Centers for Medicare and Medicaid Services,
2 the Department shall provide the MCOs with a final
3 actuarial report including the final capitation base rates
4 for the following year and subsequently conduct a final
5 capitation base review meeting. Final capitation rates
6 shall be marked final.

7 (c) For the development of capitation base rates
8 reflecting policy changes:

9 (1) Unless contrary to federal law and regulation, the
10 Department must provide notice to MCOs of any significant
11 operational policy change no later than 60 days prior to
12 the effective date of an operational policy change in
13 order to give MCOs time to prepare for and implement the
14 operational policy change and to ensure that the quality
15 and delivery of enrollee health care is not disrupted.
16 "Operational policy change" means a change to operational
17 requirements such as reporting formats, encounter
18 submission definitional changes, or required provider
19 interfaces made at the sole discretion of the Department
20 and not required by legislation with a retroactive
21 effective date. Nothing in this Section shall be construed
22 as a requirement to delay or prohibit implementation of
23 policy changes that impact enrollee benefits as determined
24 in the sole discretion of the Department.

25 (2) No later than 60 days after the effective date of
26 the policy change or program implementation, the

1 Department shall meet with the MCOs regarding the initial
2 data collection needed to establish capitation base rates
3 for the policy change. Additionally, the Department shall
4 share with the participating MCOs what other data is
5 needed to estimate the change and the processes for
6 collection of that data that shall be utilized to develop
7 capitation base rates.

8 (3) No later than 60 days after the effective date of
9 the policy change or program implementation, the
10 Department shall meet with MCOs to review data and the
11 Department's written draft assumptions to be used in
12 development of capitation base rates for the policy
13 change, and shall provide opportunities for questions to
14 be asked and answered.

15 (4) No later than 60 days after the effective date of
16 the policy change or program implementation, the
17 Department shall provide the MCOs with draft capitation
18 base rates and shall also conduct a draft capitation base
19 rate meeting with MCOs to discuss, review, and seek
20 feedback regarding the draft capitation base rates.

21 (d) For the development of capitation base rates for
22 retroactive policy or fee schedule changes:

23 (1) The Department shall meet with the MCOs regarding
24 the initial data collection needed to establish capitation
25 base rates for the policy change. Additionally, the
26 Department shall share with the participating MCOs what

1 other data is needed to estimate the change and the
2 processes for collection of the data that shall be
3 utilized to develop capitation base rates.

4 (2) The Department shall meet with MCOs to review data
5 and the Department's written draft assumptions to be used
6 in development of capitation base rates for the policy
7 change. The Department shall provide opportunities for
8 questions to be asked and answered.

9 (3) The Department shall provide the MCOs with draft
10 capitation rates and shall also conduct a draft rate
11 meeting with MCOs to discuss, review, and seek feedback
12 regarding the draft capitation base rates.

13 (4) The Department shall inform MCOs no less than
14 quarterly of upcoming benefit and policy changes to the
15 Medicaid program.

16 (e) Meetings of the group established to discuss Medicaid
17 capitation rates under this Section shall be closed to the
18 public and shall not be subject to the Open Meetings Act.
19 Records and information produced by the group established to
20 discuss Medicaid capitation rates under this Section shall be
21 confidential and not subject to the Freedom of Information
22 Act.

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

24

ARTICLE 145.

1 Section 145-5. The Medical Practice Act of 1987 is amended
2 by changing Section 54.2 and by adding Section 15.5 as
3 follows:

4 (225 ILCS 60/15.5 new)

5 Sec. 15.5. International medical graduate physicians;
6 licensure. After January 1, 2025, an international medical
7 graduate physician may apply to the Department for a limited
8 license. The Department shall adopt rules establishing
9 qualifications and application fees for the limited licensure
10 of international medical graduate physicians and may adopt
11 other rules as may be necessary for the implementation of this
12 Section. The Department shall adopt rules that provide a
13 pathway to full licensure for limited license holders after
14 the licensee successfully completes a supervision period and
15 satisfies other qualifications as established by the
16 Department.

17 (225 ILCS 60/54.2)

18 (Section scheduled to be repealed on January 1, 2027)

19 Sec. 54.2. Physician delegation of authority.

20 (a) Nothing in this Act shall be construed to limit the
21 delegation of patient care tasks or duties by a physician, to a
22 licensed practical nurse, a registered professional nurse, or
23 other licensed person practicing within the scope of his or
24 her individual licensing Act. Delegation by a physician

1 licensed to practice medicine in all its branches to physician
2 assistants or advanced practice registered nurses is also
3 addressed in Section 54.5 of this Act. No physician may
4 delegate any patient care task or duty that is statutorily or
5 by rule mandated to be performed by a physician.

6 (b) In an office or practice setting and within a
7 physician-patient relationship, a physician may delegate
8 patient care tasks or duties to an unlicensed person who
9 possesses appropriate training and experience provided a
10 health care professional, who is practicing within the scope
11 of such licensed professional's individual licensing Act, is
12 on site to provide assistance.

13 (c) Any such patient care task or duty delegated to a
14 licensed or unlicensed person must be within the scope of
15 practice, education, training, or experience of the delegating
16 physician and within the context of a physician-patient
17 relationship.

18 (d) Nothing in this Section shall be construed to affect
19 referrals for professional services required by law.

20 (e) The Department shall have the authority to promulgate
21 rules concerning a physician's delegation, including but not
22 limited to, the use of light emitting devices for patient care
23 or treatment.

24 (f) Nothing in this Act shall be construed to limit the
25 method of delegation that may be authorized by any means,
26 including, but not limited to, oral, written, electronic,

1 standing orders, protocols, guidelines, or verbal orders.

2 (g) A physician licensed to practice medicine in all of
3 its branches under this Act may delegate any and all authority
4 prescribed to him or her by law to international medical
5 graduate physicians, so long as the tasks or duties are within
6 the scope of practice, education, training, or experience of
7 the delegating physician who is on site to provide assistance.
8 An international medical graduate working in Illinois pursuant
9 to this subsection is subject to all statutory and regulatory
10 requirements of this Act, as applicable, relating to the
11 standards of care. An international medical graduate physician
12 is limited to providing treatment under the supervision of a
13 physician licensed to practice medicine in all of its
14 branches. The supervising physician or employer must keep
15 record of and make available upon request by the Department
16 the following: (1) evidence of education certified by the
17 Educational Commission for Foreign Medical Graduates; (2)
18 evidence of passage of Step 1, Step 2 Clinical Knowledge, and
19 Step 3 of the United States Medical Licensing Examination as
20 required by this Act; and (3) evidence of an unencumbered
21 license from another country. This subsection does not apply
22 to any international medical graduate whose license as a
23 physician is revoked, suspended, or otherwise encumbered. This
24 subsection is inoperative upon the adoption of rules
25 implementing Section 15.5.

26 (Source: P.A. 103-1, eff. 4-27-23.)

1 ARTICLE 150.

2 Section 150-5. The Illinois Administrative Procedure Act
3 is amended by adding Section 5-45.37 as follows:

4 (5 ILCS 100/5-45.37 new)

5 Sec. 5-45.37. Emergency rulemaking; medical services for
6 certain noncitizens. To provide for the expeditious and
7 effective ongoing implementation of Section 12-4.35 of the
8 Illinois Public Aid Code, emergency rules implementing Section
9 12-4.35 of the Illinois Public Aid Code may be adopted in
10 accordance with Section 5-45 by the Department of Healthcare
11 and Family Services, except that the limitation on the number
12 of emergency rules that may be adopted in a 24-month period
13 shall not apply. The adoption of emergency rules authorized by
14 Section 5-45 and this Section is deemed to be necessary for the
15 public interest, safety, and welfare.

16 This Section is repealed 2 years after the effective date
17 of this amendatory Act of the 103rd General Assembly.

18 Section 150-10. The Illinois Public Aid Code is amended by
19 changing Section 12-4.35 as follows:

20 (305 ILCS 5/12-4.35)

21 Sec. 12-4.35. Medical services for certain noncitizens.

1 (a) Notwithstanding Section 1-11 of this Code or Section
2 20(a) of the Children's Health Insurance Program Act, the
3 Department of Healthcare and Family Services may provide
4 medical services to noncitizens who have not yet attained 19
5 years of age and who are not eligible for medical assistance
6 under Article V of this Code or under the Children's Health
7 Insurance Program created by the Children's Health Insurance
8 Program Act due to their not meeting the otherwise applicable
9 provisions of Section 1-11 of this Code or Section 20(a) of the
10 Children's Health Insurance Program Act. The medical services
11 available, standards for eligibility, and other conditions of
12 participation under this Section shall be established by rule
13 by the Department; however, any such rule shall be at least as
14 restrictive as the rules for medical assistance under Article
15 V of this Code or the Children's Health Insurance Program
16 created by the Children's Health Insurance Program Act.

17 (a-5) Notwithstanding Section 1-11 of this Code, the
18 Department of Healthcare and Family Services may provide
19 medical assistance in accordance with Article V of this Code
20 to noncitizens over the age of 65 years of age who are not
21 eligible for medical assistance under Article V of this Code
22 due to their not meeting the otherwise applicable provisions
23 of Section 1-11 of this Code, whose income is at or below 100%
24 of the federal poverty level after deducting the costs of
25 medical or other remedial care, and who would otherwise meet
26 the eligibility requirements in Section 5-2 of this Code. The

1 medical services available, standards for eligibility, and
2 other conditions of participation under this Section shall be
3 established by rule by the Department; however, any such rule
4 shall be at least as restrictive as the rules for medical
5 assistance under Article V of this Code.

6 (a-6) By May 30, 2022, notwithstanding Section 1-11 of
7 this Code, the Department of Healthcare and Family Services
8 may provide medical services to noncitizens 55 years of age
9 through 64 years of age who (i) are not eligible for medical
10 assistance under Article V of this Code due to their not
11 meeting the otherwise applicable provisions of Section 1-11 of
12 this Code and (ii) have income at or below 133% of the federal
13 poverty level plus 5% for the applicable family size as
14 determined under applicable federal law and regulations.
15 Persons eligible for medical services under Public Act 102-16
16 shall receive benefits identical to the benefits provided
17 under the Health Benefits Service Package as that term is
18 defined in subsection (m) of Section 5-1.1 of this Code.

19 (a-7) By July 1, 2022, notwithstanding Section 1-11 of
20 this Code, the Department of Healthcare and Family Services
21 may provide medical services to noncitizens 42 years of age
22 through 54 years of age who (i) are not eligible for medical
23 assistance under Article V of this Code due to their not
24 meeting the otherwise applicable provisions of Section 1-11 of
25 this Code and (ii) have income at or below 133% of the federal
26 poverty level plus 5% for the applicable family size as

1 determined under applicable federal law and regulations. The
2 medical services available, standards for eligibility, and
3 other conditions of participation under this Section shall be
4 established by rule by the Department; however, any such rule
5 shall be at least as restrictive as the rules for medical
6 assistance under Article V of this Code. In order to provide
7 for the timely and expeditious implementation of this
8 subsection, the Department may adopt rules necessary to
9 establish and implement this subsection through the use of
10 emergency rulemaking in accordance with Section 5-45 of the
11 Illinois Administrative Procedure Act. For purposes of the
12 Illinois Administrative Procedure Act, the General Assembly
13 finds that the adoption of rules to implement this subsection
14 is deemed necessary for the public interest, safety, and
15 welfare.

16 (a-10) Notwithstanding the provisions of Section 1-11, the
17 Department shall cover immunosuppressive drugs and related
18 services associated with post-kidney transplant management,
19 excluding long-term care costs, for noncitizens who: (i) are
20 not eligible for comprehensive medical benefits; (ii) meet the
21 residency requirements of Section 5-3; and (iii) would meet
22 the financial eligibility requirements of Section 5-2.

23 (b) The Department is authorized to take any action that
24 would not otherwise be prohibited by applicable law,
25 including, without limitation, cessation or limitation of
26 enrollment, reduction of available medical services, and

1 changing standards for eligibility, that is deemed necessary
2 by the Department during a State fiscal year to assure that
3 payments under this Section do not exceed available funds.

4 (c) (Blank).

5 (d) (Blank).

6 (e) In order to provide for the expeditious and effective
7 ongoing implementation of this Section, the Department may
8 adopt rules through the use of emergency rulemaking in
9 accordance with Section 5-45 of the Illinois Administrative
10 Procedure Act, except that the limitation on the number of
11 emergency rules that may be adopted in a 24-month period shall
12 not apply. For purposes of the Illinois Administrative
13 Procedure Act, the General Assembly finds that the adoption of
14 rules to implement this Section is deemed necessary for the
15 public interest, safety, and welfare. This subsection (e) is
16 inoperative on and after July 1, 2025.

17 (Source: P.A. 101-636, eff. 6-10-20; 102-16, eff. 6-17-21;
18 102-43, Article 25, Section 25-15, eff. 7-6-21; 102-43,
19 Article 45, Section 45-5, eff. 7-6-21; 102-813, eff. 5-13-22;
20 102-1037, eff. 6-2-22.)

21 ARTICLE 999.

22 Section 999-99. Effective date. This Article and Articles
23 1, 5, 10, 130, 145, and 150 take effect upon becoming law and
24 Articles 65, 115, 120, and 135 take effect July 1, 2023.